Child Care & Medicaid: Partners for Healthy Children

A Guide for Child Care Programs

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FOREWORD

Today, approximately 12 million American children -- one in seven -- are uninsured. To reach these children, many of whom come from working families with incomes too high to qualify for Medicaid but too low to afford private health insurance, President Clinton proposed a comprehensive children's health initiative which was passed by Congress last year. This new initiative, the Children's Health Insurance Program (CHIP), set aside $24 billion over five years for states to provide new health coverage for millions of children -- the largest children's health care investment since the creation of Medicaid in 1965.

But if we are to reach these uninsured children, we have to make sure that eligible families know about these new benefits. As child care and health care professionals, you provide a critical link to parents, and I am pleased to share with you "Child Care & Medicaid: Partners for Healthy Children." I hope this important resource will help you inform families about new ways to access health coverage that children need to grow up healthy and strong.

This guide includes successful models of Medicaid outreach such as the Department's own "Healthy Child Care America Campaign," which enlists early childhood programs and a wide array of other community organizations to target children from low-income working families who may be eligible for Medicaid. States and communities involved in this campaign are developing innovative approaches to ensure the health of children, including utilizing the child care setting as an opportunity to provide preventive health services for children. In addition to Medicaid outreach, services include immunizations, hearing and vision screening, and nutrition evaluations.

Also highlighted are creative approaches that individual states and communities have developed for reaching parents with information about available Medicaid resources. Successful outreach campaigns have persuaded store owners to tuck flyers into children's shoe boxes, home-delivered pizza boxes, grocery bags, toys, back-to-school notebooks and book bags.

This guide is an invaluable, practical resource and I encourage all those who work in the child care and health care professions to use it. We need your help to ensure that every child in America has access to quality health insurance and a healthy start in life.

Donna E. Shalala

A MESSAGE FROM THE CENTER FOR MEDICAID AND STATE OPERATIONS AND THE CHILD CARE BUREAU

The Center for Medicaid and State Operations and the Child Care Bureau understand the vital role that each must play in improving the health and well-being of children in this country. We must continue to work together to enroll children who are eligible into the Medicaid program. We also must continue to work to ensure that Medicaid-eligible children have access to and receive appropriate Medicaid services. This Guide is one of many tools intended to help reach this goal.

Child care programs and child care resource and referral agencies are essential in getting children enrolled into the Medicaid program and helping Medicaid beneficiaries to access health services. To assist in that effort, this Guide presents general information about the Medicaid program and its comprehensive child health component, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). The Guide also includes appendices of additional resources, including State and Federal contacts, that will be helpful in developing an effective, organized link between child care providers and EPSDT.

We extend our sincere thanks and appreciation to our staffs and our other Federal partners for their efforts in publishing this Guide. We also acknowledge the contributions of our public and private sector partners and their continued support and interest in improving the health status of children and families in this country.

America's children are our Nation's most precious resource. We must continue to work in partnership with States, Tribes, Territories, other Federal agencies, consumers, advocacy groups, communities, health and human services providers, private sector organizations, the faith communities, and other interested groups to improve the health and well-being of our children.

Sally K. Richardson
Director
Center for Medicaid and State Operations
Health Care Financing Administration

Carmen Nazario
Associate Commissioner
Child Care Bureau
Administration on Children, Youth and Families

OVERVIEW OF THE GUIDE

This guide has been prepared for child care program administrators and child health organizations who are interested in establishing linkages with Medicaid and other State health insurance programs. This guide provides the basis for understanding the dynamics of the Medicaid program and Early Periodic Screening, Diagnostic and Treatment (EPSDT), Medicaid's comprehensive child health component. Furthermore, this guide will help child care programs and child care resource and referral agencies understand the pivotal role they can play in improving the health status of children in this country.

The guide is organized as follows:

Introduction – The introduction includes the purpose of the guide and a brief background on the collaboration between the Health Care Financing Administration and the Administration for Children and Families. It gives an overview of early childhood programs that have successful linkages with the Medicaid program, and details the benefits of establishing linkages between child care and Medicaid.

Chapter 1 – Medicaid and EPSDT – This chapter presents a general description of the Medicaid program (Title XIX), and introduces Title XXI, the State Children's Health Insurance Program (CHIP) which was created by the Balanced Budget Act of 1997 (BBA). It also describes legislation included in the BBA designed to increase children's health care coverage through the Medicaid program, namely: (1) presumptive eligibility for low-income children, and (2) the option to provide 12-month continuous eligibility. EPSDT will be most useful in making the link between child care and Medicaid. The chapter focuses extensively on EPSDT addressing the EPSDT benefit package, the State Medicaid agencies' responsibility to provide EPSDT services to children and families, and types of EPSDT service providers. Additionally, this chapter explains the relationship between the Medicaid program and managed care organizations (MCO).

Chapter 2 – EPSDT Program Activities – One of the goals of linking Medicaid with child care is to get eligible but not yet enrolled children to Medicaid services. This chapter presents various EPSDT program activities that child care programs can do to reach this goal including conducting outreach, which is a major component of EPSDT, and making appropriate referrals, facilitating and encouraging EPSDT participation, scheduling appointments and transportation and conducting case management.

Chapter 3 – Roles for Child Care Programs – The chapter identifies eight outreach activities that child care programs can do and be *"paid"* by the State Medicaid agency to bring potential eligibles into the Medicaid program and to assist in bringing Medicaid-eligible individuals into Medicaid services.

Chapter 4 – Models for Program Linkages – Sharing successful models is essential during a time of scarce resources. This chapter includes brief summaries of linkages between Medicaid and early childhood programs, child care resource and referral agencies, local health departments, and various community-based organizations. These linkages demonstrate outreach efforts that have proven to be successful and may be replicated in child care settings.

The **Appendices** include a matrix of States' Federal poverty level percentages used for determining Medicaid eligibility of pregnant women, infants and children. Each State's Maternal and Child Health toll-free number is listed to help child care programs obtain information about health care needs and resources throughout the States. The Appendices also provide reference material which will be useful to child care programs in establishing and/or enhancing collaborations with State Medicaid and Maternal and Child Health agencies, and State programs for children with disabilities. Additionally, these contacts may serve as a useful networking directory for child care programs as they develop strategies and materials for use in Medicaid outreach activities.

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Reaching children early and informing families of available comprehensive health services help support children's learning and developmental potential. Children who receive preventive and other necessary health services will be better prepared to learn and grow to be healthy productive citizens. The Health Care Financing Administration (HCFA) and the Administration for Children and Families (ACF) join in supporting and promoting the development of the health and well being of America's children.

HCFA's Medicaid program finances health services for certain individuals and families with low incomes and resources. Medicaid, a jointly funded Federal-State partnership, is administered by the States, Commonwealths, and Territories within broad Federal guidelines and provides health care coverage for more than 20 million children. While States have the flexibility to design their own Medicaid programs, each State is required to provide a package of comprehensive and preventive child health services to Medicaid-eligible individuals under age 21. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services is the name used to describe this package of health services.

The Child Care Bureau in ACF administers the Child Care and Development Block Grant (CCDBG) which provides funds to States, Territories, and Tribes to assist in providing child care services to children in low-income families, including children receiving services under the new welfare reform program, Temporary Assistance to Needy Families (TANF). Funds from this program enable parents in needy families to work or participate in education or training. These funds also may be used to serve the child care needs of families receiving protective services.

The Child Care Bureau enlists support and encourages activities that link children and their families to systems of continuous and accessible health care services. The coordination between child care programs and agencies responsible for children's health is key to supporting the healthy development of children. A good example of the Child Care Bureau's efforts is the *"Healthy Child Care America Campaign"* that encourages and supports linkages between child care and the health care community.

Purpose of the Guide

This Guide is intended for child care programs, child care providers, and child health organizations that are interested in establishing linkages with Medicaid and other State health insurance programs. It also provides a foundation for understanding the dynamics of the Medicaid program and EPSDT services. The common goal of these programs is to provide health care support for the children in their programs.

The Guide will:

- Acquaint child care programs with the benefits of Medicaid enrollment and EPSDT services;
- Discuss how child care relates to the development and/or expansion of Medicaid outreach activities;
- Discuss the pivotal role child care can play in improving the health status of children in this country; and
- Direct child care programs to additional sources of information, including models of successful program linkages.

At the end of the Guide are appendices providing additional resources which may be helpful in making a productive link between child care and Medicaid.

Medicaid and Early Childhood Programs

HCFA and ACF have a long history of collaboration. For example, the collaboration between Medicaid and Head Start has provided Head Start the opportunity to link families to a network of health services, including providing health care to certain children with disabilities. Joint efforts have focused on activities such as outreach or case finding, informing parents about services, and assistance in scheduling appointments.

LINKING HEAD START AND EARLY HEAD START WITH HEALTH

Head Start is a national program which provides comprehensive child development services for America's low-income, preschool children age three to five and social services for their families. *Head Start* is administered through the Department of Health and Human Services, Administration on Children, Youth, and Families, Head Start Bureau. Since 1965, *Head Start* has served over 15.3 million children and their families. *Head Start* serves some of the most disadvantaged children in local communities in quality developmental programs, with 10 percent of the enrollment reserved for children with disabilities.

The *Early Head Start Program*, established in 1994, expands the benefits of early childhood development to low-income families with children under three and to pregnant women. Services include quality early education in and out of the home; home visits; parent education, including parent-child activities; comprehensive health services, including services to women before, during and after pregnancy; nutrition; and case management and peer support groups for parents.

Head Start plays a major role in focusing attention on the importance of early childhood development, emphasizing the importance of the early identification of health problems. Every child is involved in a comprehensive health program, which includes immunizations, medical, dental, and mental health, and nutritional services. Recent data show that 68.7 percent of the *Head Start* children are enrolled in the Medicaid/Early Periodic Screening, Diagnostic, and Treatment (EPSDT) program which pays for their medical and dental services. The revised Head Start Program Performance Standards, effective January 1, 1998, use the EPSDT schedule of well child care as the standard for a child health screen.

Analysis of recent Medical Expenditure Panel Survey data supports the need and benefits for linking Medicaid with early childhood programs.[1] The data showed that there are 4.7 million children age 18 and under who are uninsured despite being eligible for Medicaid. The reasons for such a large number of Medicaid-eligible children not enrolled in the program are undoubtedly many. However, lack of knowledge and information about who is eligible for Medicaid may be a major reason.

[1]Selden, Thomas M., Banthin, Jessica S., Cohen, Joel W.:**Medicaid's Problem Children: Eligible But Not Enrolled.**Health Affairs, May/June 1998: Agency for Health Care Policy and Research.Medical Expenditure Panel Survey.

Also, more recent legislation de-linked Medicaid from welfare, so that coverage under Medicaid is no longer based upon whether a family receives public assistance and may make it difficult for families to become enrolled in Medicaid. In addition, many families are unaware of the 1989 legislative changes which expanded Medicaid eligibility. Now, all children under age 6, including those of low-income working families, whose family incomes are below 133 percent of the Federal Poverty Level (FPL) can enroll in Medicaid. Some States have chosen to raise the income standard to 185 percent of the FPL and higher (see Appendix A). In addition, children who are 5 years and under can receive services through the Supplemental Nutrition Program for Women, Infants, and Children (WIC) if they are at nutritional risk with family incomes below 185 percent of the poverty level.

LINKING U.S. DEPARTMENT OF AGRICULTURE (USDA) PROGRAMS WITH HEALTH

Supplemental Nutrition Program for Women, Infants, and Children (WIC) is administered by the U.S. Department of Agriculture (USDA) and currently serves more than 3 million children monthly who are 5 years of age and under. The *Food Stamp Program*, also administered by USDA, reaches about 14 million children each month, and the *Child and Adult Care Food Program* serves about 1.8 million children a year.

The *WIC* Program improves the nutritional health of low-income women, infants, and children by providing nutritious, supplemental foods, and nutrition information. Participants receive vouchers that can be redeemed at retail food stores for specific foods that are rich sources of the nutrients frequently lacking in the diet of low-income mothers and children. In addition, the *WIC* Program is a gateway to a variety of health and social services. *WIC* has been shown to be effective in improving the health of pregnant women, new mothers and their infants. Children have always been the largest category of *WIC* participants. In addition, *WIC* and Medicaid working closely with early childhood programs can ensure that preschool children have access to all programs for which they may be eligible.

In addition, some private sector organizations have promoted linkages between Medicaid and early childhood programs. For example, in 1994 the Center on Budget and Policy Priorities[2] initiated a national outreach campaign called "*Start Healthy, Stay Healthy.*" The campaign enlists early childhood programs and a wide array of other community organizations to link children to health and nutrition benefits available through Medicaid and WIC. Also, with the recent creation of the State Children's Health Insurance Program, the campaign has expanded to help get children enrolled in enlarged or newly-created State child health insurance programs and help to promote coordination between such programs and Medicaid.

Benefits of Child Care and Medicaid Linkages

It is well-known that maintaining a child's health leads to a more productive and better quality of life for the child. Linking child care programs with Medicaid and other State child health programs can be especially beneficial to young children, as health conditions that are not prevented or treated can easily progress to chronic diseases and lifelong barriers to self-sufficiency.

Often, a child care facility is the first place a child comes in contact with the Medicaid program. Millions of children spend all or part of their days in some type of early childhood setting while their parents work or participate in an education program. Recent changes in public assistance programs have encouraged larger numbers of beneficiaries to work or attend work programs. This greatly increases the need for child care. Low-income working parents too often have jobs that provide little or no health insurance coverage. Because they work, they think they earn more money than that allowed to be eligible for Medicaid or other publicly financed health insurance programs. They may not know that although they work and have some health insurance through their jobs, their children may still qualify for Medicaid. Most of the children receiving child care funded by the CCDBG live in families whose incomes are below

[2]The Center on Budget and Policy Priorities, a private non-profit organization, is located at 820 First Street, NE, Suite 510, Washington, DC 20002, Web site: <<http://www.cbpp.org>>.

100 percent of the FPL. Analysis of 1995 CCDBG data indicates that one fourth of the children have family incomes between 100 and 150 percent of the FPL.

Benefits of Linkages

Linking Medicaid and child care services offers numerous benefits:

- An opportunity to identify uninsured children and speed up enrollment in the Medicaid program, other State-offered health insurance programs, and WIC programs;
- An avenue to help families identify and access quality health care services;
- The chance to assist with identifying and removing barriers to health care;
- Early detection of illnesses and/or diseases;
- Maximizing resources and eliminating duplication by combining the application process for child care subsidies or other forms of assistance with a preliminary Medicaid and/or other State health insurance program application;
- Linking families to a network of health and developmental services to improve the quality and efficiency of delivering health services for children. The ***"Healthy Child Care America Campaign"***, for example, promotes the healthy development of children in child care;
- Child care settings are ideal sites for the delivery of immunizations, health screenings, nutrition programs, health consultations, and referral services;
- Child care settings offer friendly, familiar settings to help parents understand health issues that may be culturally sensitive; and

- An opportunity to reach child care providers whose own children may qualify for Medicaid or other State-offered health insurance.

THE HEALTHY CHILD CARE AMERICA CAMPAIGN
"LINKING CHILD CARE AND HEALTH"

The *"Healthy Child Care America Campaign"* is a collaborative initiative between the Administration for Children and Families' Child Care Bureau and the Health Resources and Services Administration's Maternal and Child Health Bureau, U.S. Public Health Service. The goal of the *Campaign* is to promote the healthy development of children in child care. The *Campaign* supports and encourages partnerships between health and child care in communities across the country to improve the health and safety of the millions of children in child care settings. Presently, forty-eight States, the District of Columbia, Puerto Rico and Palau have launched *"Healthy Child Care Campaigns"* through an integrated systems approach - integrating health, child care and social services.

States and communities involved in these unique partnerships are developing innovative approaches to ensure the health of children, including utilizing the child care setting as an opportunity to assure access and/or provide preventive health services to children. Services include immunizations, hearing and vision screening, nutrition evaluations and providing Medicaid outreach to enroll eligible children. Medicaid can fund outreach efforts among child care networks to enroll eligible children into the program. The *"Healthy Child Care America Campaign"* is helping communities form partnerships and share promising practices.

CHAPTER 1

MEDICAID AND EPSDT

It is essential to reach children as early as possible to help ensure their total well-being in the future. Child care programs can be a valuable resource in this process by informing children and families about Medicaid and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT). The major advantage child care programs have in providing information comes from their daily interaction with young children and their parents or guardians.

This chapter will help child care programs understand Medicaid and EPSDT. The EPSDT component will be most useful in making the link between child care and Medicaid. For more specific information about EPSDT in a particular State, contact the State Medicaid EPSDT Coordinator (see Appendix D).

What is Medicaid?

Medicaid, Title XIX of the Social Security Act, is a program that provides medical assistance for certain individuals and families with low incomes and resources. The program became law in 1965 as a jointly-funded cooperative venture between the Federal and State governments to assist States in the provision of adequate medical care to eligible needy persons. Medicaid is the largest program providing medical and health-related services to America's poorest people. Within broad national guidelines that the Federal Government provides, each of the States:

- Establishes its own eligibility standards;
- Determines the type, amount, duration, and scope of services;
- Sets the rate of payment for services; and
- Administers its own program.

Recent Legislation

State Children's Health Insurance Program (CHIP)

The Balanced Budget Act of 1997 (BBA) created Title XXI of the Social Security Act, also referred to as the State Children's Health Insurance Program. CHIP offers new opportunities for low-income families to have health insurance protection for their children. Its primary focus is to initiate and expand health insurance coverage for low-income uninsured children. The program allows States to expand health insurance coverage for children in one of three ways: through a separate child health insurance program, through the Medicaid program, or through a combination of these programs.

For more information on CHIP, visit the Web site: <<www.hcfa.gov/init/children.htm>> or contact the HCFA regional office which serves your State (See Appendix C).

Medicaid Expansions

The BBA also included two additional provisions giving States the option to increase children's health care coverage through the Medicaid program: (1) presumptive eligibility for low-income children, and (2) the option to provide 12-month continuous eligibility.

- **Presumptive Eligibility Option** – Certain "qualified entities" may enroll children under 19 years of age in Medicaid on a temporary basis if they appear to be eligible based on their ages and family income. Qualified entities may include children's traditional health care providers, such as pediatricians and health professionals who deliver services in community health centers, WIC programs, Head Start programs, and **State and local agencies that determine eligibility for subsidized child care under the Child Care and Development Block Grant (CCDBG) Act.**

Many child care agencies and Head Start programs already are engaged in efforts to inform working parents about the Medicaid program. Presumptive eligibility could effectively link these outreach activities to the eligibility process. It can be a particularly useful tool for enrolling children in Medicaid who are not receiving public assistance and whose parents are employed at low-wage jobs not offering health insurance coverage.

- **Twelve-Month Continuous Eligibility Option**—States can guarantee up to 12 months of coverage to children enrolled in Medicaid even if the child experiences changes in family income or other circumstances that would make the child ineligible for Medicaid during the 12-month period.

What is EPSDT?

EPSDT is the child health component of the Medicaid program. It provides a comprehensive set of preventive and health care services to most Medicaid-eligible individuals under age 21. Under the EPSDT component, States are required to provide a broad range of activities in addition to general Medicaid program requirements. These include health services, data reporting, and conducting outreach, i.e., States are required to provide for a combination of written and oral methods designed to inform EPSDT eligible individuals (or their families) about the EPSDT program. While the Federal term for this set of required services is EPSDT, many States have chosen different names for their individual programs. For example, Vermont calls its EPSDT program "Dr. Dinosaur." The term EPSDT describes the program's goals and gives information about the services that it covers:

Early: assessing a child's health early in life so that potential diseases and disabilities can be prevented or detected in the early stages, when they can be most effectively treated;

Periodic: assessing a child's health at key points in her/his life to assure continued healthy development;

Screening: the use of tests and procedures to determine if children being examined have conditions requiring closer medical (including mental health) or dental attention;

Diagnostic: determination of the nature and cause of conditions identified by screenings and those that require further attention; and

Treatment: the provision of services needed to control, correct, or reduce physical and mental health problems.

What Services are Covered Under EPSDT?

Each State must develop a State Plan which lists the eligibility criteria and covered services as well as other information required by Federal regulations. Like other health insurance programs, State Medicaid programs sometimes limit the type of covered services or the duration of the service. However, these limits do not apply to children eligible for EPSDT services. For example, Medicaid-eligible children may receive health services which may not be covered in the State Plan for adults, such as dental services. States are required to cover the following services under the EPSDT component:

- Screening services – the core of the EPSDT benefit package – must include:
  - ✔ A comprehensive health and developmental history, including a physical and mental health assessment,
  - ✔ A comprehensive unclothed physical examination,
  - ✔ Appropriate immunizations according to the schedule of the Advisory Committee on Immunization Practices (ACIP),
  - ✔ Laboratory tests, including blood lead level, and
  - ✔ Health education, including anticipatory guidance;

- Dental services, including restoration of teeth and maintenance of dental health;
- Hearing services, including hearing aids;
- Vision services, including eyeglasses;
- Any other necessary health care diagnostic services, and treatment coverable by Medicaid, whether or not the service is covered under a particular State's Medicaid Plan, to correct or improve illnesses and conditions found in screening; and
- Assistance with transportation and scheduling of appointments.

Screening services must be available in accordance with a State's timetable (periodicity schedule). States must consult with medical and dental organizations involved in child health care to develop age-appropriate periodicity schedules. Screening services also should be available at times other than the regularly-scheduled intervals, if there is reason to suspect an illness or condition that did not exist or was not identified at the regular periodic screening.

Diagnostic services are covered whenever a screening examination indicates the need to conduct a more in-depth evaluation. The purpose of diagnosis is to determine the nature, cause, and extent of the problem found by the screening examination. This diagnosis may then result in development of a plan for treatment.

Treatment services are covered whenever they are medically necessary to correct or improve defects, physical or mental illnesses, or other conditions discovered through an EPSDT screening.

In general, EPSDT treatment services include all mandatory and optional services available under the Medicaid program. These optional services include: case management, physical therapy, rehabilitative services, and private duty nursing. Diagnostic

services and treatment are covered whenever there is a medical need to conduct further examination. Some enabling services also are required under the EPSDT component. For example, assistance with transportation and scheduling appointments must be offered and made available to ensure that beneficiaries obtain needed health services.

Who Can be Served?

Most children under age 21 who are eligible for Medicaid are automatically eligible for EPSDT services and can receive them any time. Family income is a main criterion used to determine Medicaid eligibility, but not all children in families with incomes below the FPL are eligible for Medicaid. When a child is determined to be Medicaid-eligible, information is given to the family regarding EPSDT services; they have the option whether to utilize these services or not. If, at first, the family decides not to utilize EPSDT services, they can obtain these services for the child at a later time.

Children under age 21 can qualify within a variety of groups, including:

- Individuals who meet the requirements of the former Aid to Families with Dependent Children (AFDC) program and, in some States, those who meet the requirements of the new Temporary Assistance for Needy Families (TANF) program;

- Beneficiaries of Supplemental Security Income (SSI) in most States - (The new children's health legislation requires States to continue Medicaid coverage for all disabled children who were receiving SSI on August 22, 1996 but who lost their Medicaid eligibility as a result of the 1996 changes in the definition of a child with a disability.);

- Beneficiaries of adoption assistance and foster care under Title IV-E of the Social Security Act;

- Infants under age 1 and children under age 6 in low-income families whose earnings are at or below 133 percent of the FPL (or a higher percentage in several States that have expanded these eligibility guidelines for children); and

- All children born after September 30, 1983 in families with incomes at or below 100 percent of the FPL. This phases in coverage so that all children under age 19 in such families will be covered by the year 2002.

Some States provide coverage to additional groups of individuals beyond the mandated provisions.

Who Provides EPSDT Services?

Ideally, EPSDT services are part of a continuum of care in which the child's health care services are always delivered by someone who is familiar with his or her health history and family situation. EPSDT services may be provided by a physician, nurse practitioner, pediatrician, or other type of health care provider who is certified by the State Medicaid program to be a Medicaid provider.

States cannot limit EPSDT providers to only those who can provide all EPSDT diagnostic and treatment services. If more than one provider is needed to complete the full range of EPSDT services to a child, these services should be coordinated to ensure the child receives all the necessary services and to avoid duplication. However, most children who have a family health care provider will receive most of their EPSDT screening, diagnostic, and treatment services from the same provider. Services may be furnished by qualified providers located in child care and Head Start programs, school-based health centers, State and local health departments, managed care organizations (MCO), physician offices, Indian Health Service Centers, and Community Health Centers.

Today, there is a growing trend toward using non-office sites, particularly school-based and school-linked health centers, as EPSDT providers, especially for the screening component of services. The growing popularity of school-based health centers as EPSDT providers

is attributed to State and local initiatives designed to improve children's health care access. School-based centers provide close proximity to the targeted population and tailor their services to ensure age-appropriate preventive care. Most facilities are located in middle or secondary schools, although they are becoming more common at the elementary school level.

The Individuals with Disabilities Education Act (IDEA) provides for special education services in the schools. Part C of IDEA is the early intervention program for infants and toddlers. Each child receiving special education services has an Individualized Family Service Plan (IFSP) which details the services the child needs. Medicaid can pay for some health-related services required under the IFSP.

Child care programs can play an important role in helping young children receive the services they need to enhance development potential and learning. If a child care provider suspects that an infant or child has a physical disorder or developmental delay, they can help the parent or guardian contact the local office responsible for providing services to children with special health care needs. The child care provider also can help the parent or guardian contact the local Medicaid office.

What is the State Medicaid Agency's Responsibility?

State EPSDT components are often part of a larger network of social service agencies and health programs for children and families. Coordination among these entities is essential to ensure and maximize access to services and to prevent duplication. Medicaid agencies are required to coordinate with Maternal and Child Health Programs (MCH) and WIC. They also are encouraged to coordinate with child care and Head Start agencies, State and local education agencies, and social service agencies. These collaborative efforts may include interagency agreements, cross-referrals, child health coordinating committees from Head Start projects, and other activities that stimulate partnerships in ensuring health care for children.

States are required to:

- Seek out eligible children and families to:
  - ✔ Encourage their participation in Medicaid/EPSDT,
  - ✔ Inform them of the availability and benefits of preventive services,
  - ✔ Provide assistance with scheduling appointments and transportation, and
  - ✔ Help families use health resources effectively and efficiently;
- Assist families in finding EPSDT providers;
- Assure that providers assess health needs through initial and regular periodic examinations; and
- Assure that detected health problems are diagnosed and treated early before those problems become more complex and their treatment more costly.

Who Pays for Services?

State Medicaid agencies (SMA) are responsible for paying for medical and some non-medical services which are covered under the State Plan provided to Medicaid beneficiaries. Each SMA establishes its State-specific rates which usually are available to any qualified provider who agrees to provide the service. Regarding administrative services, SMAs have the flexibility to enter into contractual arrangements consistent with applicable State and Federal contracting requirements. Some contractual arrangements may be with other Federal and State agencies, schools, community-based organizations, providers of transportation services, child care programs, and child care resource and referral agencies (CCR&R). For example, Louisiana's Department of Health and Hospitals

contracts with community-based organizations to become Medicaid Application Centers. Trained staff at these centers conduct initial processing functions that enable the SMA to determine Medicaid eligibility. SMAs can enter into contractual arrangements with MCOs. Payments to MCOs are based on a capitated rate, and MCOs have great flexibility with respect to negotiating and establishing that rate.

State expenditures are matched by the Federal government for a share of the costs they spend for Medicaid services. The Federal share varies from one State to another. Expenditures for medical services, including screening, diagnosis, and treatment, are reimbursed by the Federal government at State-specific rates. This rate varies from 50 to 83 percent with poorer States receiving a higher rate for the cost of Medicaid medical services and wealthier States receiving a lower rate. Administrative expenses for activities such as outreach, eligibility determinations, provider relations, some transportation activities, and follow-up are usually matched by the Federal government to the SMA at a rate of 50 percent.

Medicaid Managed Care

The significant shift from individual providers to managed care plans makes it essential that child care and affiliated programs understand the relationship between the Medicaid program and managed care organizations (MCO). An MCO is a health system that combines the delivery and financing of health care services. Managed care also can mean a system in which an individual primary care provider coordinates all care, including referrals to specialty services. It is broadly defined as an arrangement among the SMA, the Medicaid beneficiary, and health services providers. MCOs offer many medical specialities and services for their members. These organizations have the potential to offer increased access to preventive and primary health care for enrollees.

States efforts to enroll Medicaid beneficiaries into managed care have dramatically increased over the past few years and current data suggest that the trend will continue. As of June 30, 1997, approximately 15.4 million beneficiaries, or 48 percent of the

national Medicaid population, had been enrolled in managed care programs.[3]

While there are many different types of managed care arrangements, there are general characteristics regarding the delivery and financing of services. For delivery of services, patients must be enrolled with a primary care provider who is responsible for the coordination of care. Primary care physicians furnish patients with access to selected provider networks in which services are coordinated with a focus on prevention and early detection of illnesses and conditions.

Managed care plans are generally paid a set amount (a capitation rate) in advance for providing an agreed-upon package of health services. In exchange for the prepaid premium, many managed care plans assume financial risk for the provision of this benefit package. The managed care plans also establish a provider network, pay providers, and educate providers and enrollees about the covered services available under the plan.

States and managed care plans often must coordinate and contract with providers outside of the managed care plans' provider networks to ensure that EPSDT services are provided. Sometimes a service that is covered under the EPSDT benefit package is defined as a "carve out" (not included) under the State managed care contract. When services are carved out, managed care plans are not contractually obligated to provide them, and thus, beneficiaries may go to any other Medicaid provider to receive these services. However, the SMA or the MCO is required to coordinate the provision of these "carve out services" depending on the terms of the MCO contract.

Sometimes entire services are carved out and placed in another managed care program. The most common service that is carved out is mental health. This means there may be two managed care programs

[3]U.S. Department of Health and Human Services, Health Care Financing Administration, Data & Systems Group: *Medicaid Managed Care Enrollment Report*, June 1997.

that families must understand. Sometimes, these two systems do not coordinate very effectively so it is helpful when other service providers understand the two systems.

Beneficiaries sometimes become confused when they are required to receive the majority of their health care from a certain provider but must obtain the remaining services outside the plan's network. For that reason, education campaigns designed to increase beneficiaries' understanding of the services to which they are entitled, as well as where and how to access those services, becomes even more critical.

In other cases, community providers, such as school-based health centers and child care programs, may be best situated to serve children and adolescents. These programs are likely to be readily accessible and knowledgeable about the unique needs of low-income children and adolescents. To ensure the appropriate provision of health care, arrangements between the managed care plans and the community providers must include assurances of coordination of care and followup.

Varying degrees of coordination between MCOs and child care programs are possible. Establishing a relationship with MCOs as early as possible is important after the children are enrolled in the MCO. One possible arrangement is for the State agency and/or the MCO to reimburse the child care program for providing outreach; e.g., health education campaigns and other administrative services to families and children.

To find out more about special arrangements a State may have with MCOs, contact the State Medicaid agency (see Appendix D) or visit the HCFA Web site: <<www.hcfa.gov>>.

CHAPTER 2

EPSDT PROGRAM ACTIVITIES

This chapter describes Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program activities and the potential roles child care programs can play in these activities. These activities include: conducting outreach and making appropriate referrals, facilitating and encouraging EPSDT participation, scheduling appointments and scheduling transportation, performing periodic renotifications, and conducting case management. By performing and/or participating in these program activities, Child care programs have a broad potential to link eligible but not-yet-enrolled children to Medicaid services.

Outreach and Referral

Outreach is a required, major component of EPSDT. While States have the flexibility to design and conduct their own Medicaid outreach programs, i.e., outreach targeted at enrolling children in Medicaid, States are required to ensure that all eligible Medicaid beneficiaries who are under age 21 are informed about EPSDT services, including age-appropriate immunizations. This must be done within 60 days of their Medicaid eligibility determination and annually thereafter in instances in which eligible beneficiaries have not accessed services during the year. Both States and health care providers who serve Medicaid beneficiaries may inform eligible individuals about the program and emphasize the important role of preventive health care.

Child care programs and CCR&R agencies can participate in outreach. Key parts of an outreach strategy may include:

- Encouraging and facilitating enrollment in Medicaid and participation in EPSDT services;
- Informing the family about available EPSDT services and support services;
- Explaining EPSDT services in a clear, simple way; and
- Promoting the advantages of early detection and treatment.

Through innovative outreach initiatives performed in local communities through child care programs, emphasis on preventive health care should be made in a culturally sensitive manner. Likewise, these programs provide the opportunity to encourage participation in EPSDT through educating families in combination with outreach activities.

Participation

Child care programs also have the opportunity to play a role in encouraging EPSDT participation. They can assist families who choose to utilize EPSDT services by helping families arrange a health screening appointment. They also can obtain lists of Medicaid providers, including MCOs, from the SMA to help families select health care providers.

Appointments and Transportation

When moving into the screening phase of EPSDT, the child's family can either make an appointment for screening services individually or the Medicaid agency staff may help in scheduling the appointment. The Medicaid agency must offer and provide transportation assistance for such appointments when needed. Child care programs can assist families with scheduling appointments and arranging for transportation.

Periodic Renotification

At intervals set by each State, eligible children should be re-screened in order to maximize preventive health efforts. These intervals are relatively short in the first few years of life and get longer as the child gets older. The State is responsible for ensuring that renotification occurs. Medicaid agencies could contract with child care programs and CCR&R agencies to have them carry out the periodic renotification function.

Child care programs and CCR&R agencies can:

- Assist in reminding families of the next screening examination;
- Assist in facilitating rescreening exams;
- Remind families of the benefits of participating in EPSDT; and
- Offer necessary support services for them to successfully complete the screening examinations.

Case Management

The purpose of case management is to help enrolled children and families through the often confusing system of health and related services in their communities. Since EPSDT screening, diagnostic, and treatment activities are frequently not conducted at one time or in one place, case management is important to ensure that children receive appropriate services on a timely basis. Among other things, case managers may:

- Assist families in identifying and choosing health providers, and maintaining a "Health Home";
- Facilitate contacts between the Medicaid/EPSDT program and the family to verify activities, maintain records, and assure an efficient and accurate flow of information;
- Conduct followup measures to assure that children receive needed diagnosis and treatment;
- Help families maintain contact with health providers and provide ongoing counseling to answer questions and reduce feelings of uncertainty about the programs; and
- Teach families skills to become their own case managers.

Child care programs are well-suited to assist in the case management process. They have the capacity to provide a variety of administrative services which are similar to those case management services needed for EPSDT and which could be incorporated into their existing system. Child care programs interested in expanding their services to case management, or who are currently practicing it, may contact the local Medicaid agency for more information (see Appendix D).

Service Delivery

Child care programs have the potential to play several different roles in delivering EPSDT services to children. Sometimes nurses or nurse practitioners conduct EPSDT screenings on site at child care and Head Start programs, and then children are referred to community providers for diagnostic and treatment services. Child care programs could partner with the local public health departments or other health care provider organizations to explore ways of conducting on-site screenings for children in child care.

CHAPTER 3

OUTREACH ROLES FOR CHILD CARE PROGRAMS

Whenever a family is asked to provide family size and income information, this presents an opportunity for Medicaid and EPSDT outreach and referral. This information may be requested to determine eligibility for subsidized child care, Child and Adult Care Food Program (CACFP), Head Start, WIC, school nutrition programs, energy assistance programs, food stamps, and cash assistance. Agencies requesting this information can expand their own intake procedures to help families make connections with Medicaid.

This chapter describes various outreach activities child care programs and child care resource and referral agencies (CCR&R) can do to: (1) bring potential eligibles into the Medicaid system for determining Medicaid eligibility, and (2) bring Medicaid-eligible individuals into Medicaid services.

Under contractual arrangements with State Medicaid agencies, child care programs and CCR&R agencies can be paid for doing the following outreach activities:

1. Assisting families in completing Medicaid applications:

- Making presumptive eligibility determinations in States that have selected this option. **(This applies only to CCR&Rs and child care programs that are authorized to determine eligibility for subsidized child care under the CCDBG Act - For a list of entities authorized to make presumptive eligibility determinations, refer to Chapter 1, section titled Recent Legislation, Presumptive Eligibility Option.)**; and

- Assisting with initiating the Medicaid application process, and helping individuals reapply for Medicaid; e.g., combining child care income evaluations for child care subsidies with a preliminary Medicaid and/or other State health insurance eligibility screening - In Louisiana the SMA pays the Head Start agency for completed Medicaid applications:

- ✔ Explaining the Medicaid eligibility process to prospective applicants,

- ✔ Gathering information needed for the application and eligibility determination including resource information and third-party liability information (other health insurance coverage or available health insurance), in preparation for submitting a formal Medicaid application,

- ✔ Providing the necessary forms and assembling all forms in preparation for Medicaid eligibility determinations.

2. Assisting the Medicaid agency to fulfill outreach objectives of the Medicaid program:

- Informing Medicaid eligible and potential Medicaid-eligible children and families of the benefits of preventive health and mental health services of the Medicaid program; and

- Informing children and their families of ways to effectively use and maintain participation in all health resources under the Medicaid program.

3. Assisting the Medicaid agency to fulfill objectives of the EPSDT component:

- Informing families about the early diagnosis and treatment services for health and mental health conditions that are available through EPSDT;

- Assuring that health problems found are diagnosed and treated early, before they become more serious and their treatment more costly; and

- Informing beneficiaries of the benefits of preventive services.

4. Assisting families in obtaining services:

- Making appropriate health care referrals;
- Assisting families with scheduling appointments and arranging transportation - contacting children and families by telephone or through personal letters (being sensitive to the reading level of the population enhances this process);
- Helping children and their families to effectively and efficiently use Medicaid health resources; and
- Assisting families in accessing Medicaid managed care systems.

5. Informing families about Medicaid through brochures or other promotional material:

- Conducting health education campaigns, and health fairs targeted specifically to Medicaid services and for Medicaid-eligible individuals (***note: Health education for patients and families is a required component of an EPSDT screen and is not separately reimbursed as an administrative activity***);
- Contacting pregnant and parenting teenagers about the availability of Medicaid, prenatal, and well-baby care programs and services;
- Obtaining materials from the SMA or county office and distributing posters, booklets and easily-understood, culturally-sensitive educational materials about Medicaid and the benefits of EPSDT;

- Handing out brochures and referring individuals to the local medical assistance office to apply for Medicaid or provide information on other options such as applying by telephone or mail-in applications; and

- Assisting in early identification of children with special medical and/or mental health needs through various child find activities.

To avoid duplicating existing community outreach programs, child care programs and CCR&R agencies should identify what is already being done and find creative additions to link their programs with Medicaid. In addition to finding useful alternatives, this type of outreach will accelerate progress toward the overall goal of providing health care to all Medicaid-eligible children. A good starting place is to contact the State Medicaid programs and MCH (Title V) programs. Since State MCH programs are required to conduct a needs assessment, they have useful information on health care needs and resources throughout the State (see Appendix B, *"State MCH Programs-Hotline List of Toll Free Telephone Numbers"*).

Payment For Providing Outreach Services

State Medicaid agencies are allowed to claim outreach as an administrative expenditure under the Medicaid program. The Federal government provides matching funds to States for conducting specific outreach activities.

In order to be reimbursed for performing outreach activities, child care programs and CCR&R agencies **must** have a contract with the SMA. Rates for performing outreach activities are set by the SMA. The State agency will establish the conditions of reimbursement with the child care program. Included in Appendix D is a list of State Medicaid agency contacts.

CHAPTER 4

MODELS OF PROGRAM LINKAGES

This chapter provides models of program linkages between early childhood programs and Medicaid. The models were researched and developed by the Center on Budget and Policy Priorities. The various models illustrate ways early childhood programs have undertaken outreach activities to help bring potential eligible individuals into the Medicaid program, and to assist Medicaid beneficiaries in accessing health services. The following models are presented as examples that may be replicated in a child care setting.

MODELS OF PROGRAM LINKAGES

DISSEMINATE INFORMATION ABOUT MEDICAID AND PROVIDE APPLICATION MATERIALS

Posters and flyers should include information about who is eligible, as well as where and how to apply. Be sure to tell families about application sites other than the welfare office. It is increasingly important to let families know they may be eligible for Medicaid whether or not they qualify - or even apply - for cash assistance. If your State has a short, mail-in Medicaid application, keep a supply on hand to give to families. Always provide a checklist of documents that must be submitted with the form.

Maryland – "*LOCATE: Child Care*," a Statewide CCR&R agency based in Baltimore at the Maryland Committee for Children, refers families who call the program's community line to appropriate and affordable child care. To determine whether families may be eligible to receive child care subsidies, "*LOCATE*" routinely asks callers about family income and their participation in a variety of public benefit programs. "*LOCATE*" revised its intake questionnaire to accurately screen for Medicaid (and WIC) eligibility. A process for referral to Medicaid was developed in conjunction with the Maryland Department of Health and Mental Hygiene (DHMH) and the State Medicaid agency. Now, when children of families that call

the community line are found likely to be eligible for Medicaid, a State-prepared brochure describing Medicaid services is mailed to the family, along with information on where and how to apply for benefits. State Medicaid officials trained *"LOCATE's"* family counselors to be able to answer parents' questions about Medicaid over the telephone. In addition, *"LOCATE"* worked with DHMH and the State's Child Care Agency to provide information on Medicaid to all licensed child care programs.

INCORPORATE MEDICAID INCOME ELIGIBILITY SCREENING AS PART OF YOUR PROGRAM'S ROUTINE INTAKE

Income eligibility for one program can "flag" eligibility for Medicaid if the income guidelines are similar. Once you identify a child likely to be eligible for Medicaid, at a minimum, refer the family to a place where an application can be submitted. Better yet, assist the family in completing a Medicaid application at the same time the family applies for other benefits, such as subsidized child care, Head Start, or Child and Adult Care Food Program meals. This will be relatively easy if your State has a simple, mail-in Medicaid application.

Alabama – The Child Care Resource Center in Opelika, Alabama, is one of 12 management agencies under contract with the State Department of Human Resources to determine eligibility for subsidized child care. Since Alabama's income eligibility guidelines for subsidized child care are lower than the State's Medicaid eligibility guidelines for children under age 6, it is easy for counselors to identify children likely to qualify for Medicaid. If the child is not enrolled in Medicaid already, the counselor helps the parent complete Alabama's short Medicaid application at the same time the application for subsidized child

care is completed. The counselors ensure that the completed applications are delivered to the Medicaid office. In Alabama, Medicaid applications can be mailed in and applicants do not need to have a face-to-face interview. If a parent reports that the child already is enrolled in Medicaid, the counselor takes the time to discuss the importance of EPSDT benefits and how families can utilize them.

California – As part of its child care resource and referral services, the *"Children's Council of San Francisco"* collects family income information to determine whether a child is eligible to receive a child care subsidy. The *"Children's Council"* uses this income information to identify children who may be eligible to receive health services through Medicaid (called MediCal in California). Referral of such children to MediCal is done routinely. In 1995, the *"Children's Council"* and the City and County of San Francisco Department of Social Services joined forces to make Medicaid enrollment easier for working parents. The *Children's Council* sent letters to all parents with children on its waiting list for subsidized child care advising them that their children appeared to be eligible to receive health insurance through MediCal. Families were invited to meet with MediCal enrollment workers at the *"Children's Council"* satellite office on a Saturday morning. This meant parents could enroll their children in a familiar, comfortable setting at an hour that did not require them to take time off from their jobs. Bilingual enrollment workers were available to assist parents in Spanish and Cantonese. Child care also was provided.

WORK WITH YOUR STATE OR LOCAL MEDICAID AGENCY TO BECOME A MEDICAID OUTSTATION, OR ARRANGE FOR MEDICAID ENROLLMENT WORKERS TO VISIT YOUR CENTER ON A REGULAR BASIS

Workers employed by the State can take applications and determine eligibility. State employees need not be "stationed" at any particular child care program all the time; they may rotate among several locations. Your own staff can be trained to conduct "initial processing" of applications — helping families complete the Medicaid application and gather the documents they need to submit along with it so that eligibility can be determined by the State agency. States can contract with child care programs and community organizations to conduct such activities.

Louisiana - Louisiana's Department of Health and Hospitals contracts with community-based organizations to become Medicaid Application Centers. The LaFourche Parish Head Start Program, serving approximately 520 children, participates in the program. Head Start staff are trained and certified by the State to complete Medicaid applications. Throughout the year, staff members contact families that appear to have children eligible for Medicaid. Medicaid information is provided to parents through individual classroom orientations, and monthly parent newsletters and flyers are posted throughout the agency. Teachers also refer families to the Medicaid-certified staff for assistance. Medicaid-certified staff offer opportunities for parents to fill out applications when they drop off or pick up their children. Head Start's costs for providing this valuable service are reimbursed with Medicaid administrative funds; certified Medicaid Application Centers receive $14 for each completed application.

Be sure the Medicaid outstation site addresses the needs of applicants in the community. For example, child care could be provided so parents can give their attention to completing the application. Interpreters may be offered for applicants who speak languages other than English. Hours should be scheduled that are convenient for working families, such as early mornings, evenings or weekends.

CONDUCT MEDICAID OUTREACH AT SPECIAL EVENTS

Health fairs, child care open house or parent meetings, Head Start recruitment day, kindergarten registration, community festivals, or story hour at the library offer opportunities to talk to families about health insurance for their children. Be there – any place, any time families and children are likely to gather.

New Mexico – In New Mexico, the Laguna Pueblo, Division of Early Childhood, conducts an annual event called *"Child Find"* in seven villages. During *"Child Find"* activities, children under age 5 receive comprehensive screening for developmental, nutritional, medical, vision, dental, and hearing problems. Children with special needs are identified and appropriate referrals are made. Flyers and posters promoting the *"Child Find"* are distributed by members of the Laguna Interagency Coordinating Council for Young Children, and through schools, post offices and local merchants. Upon entering the *"Child Find,"* each parent is asked whether the child has private health insurance or is enrolled in Medicaid. If not, a social worker from the Indian Health Services hospital facility is on hand to assist parents in filling out New Mexico's three-page Medicaid application. In 2-3 weeks the social worker checks in with the family to ensure that the process has gone smoothly and to find out if the child's Medicaid eligibility has been approved. They can provide assistance if there are any procedural problems.

DURING HOME VISITS, SHARE MEDICAID INFORMATION AND ASSIST FAMILIES IN APPLYING FOR THE PROGRAM

Home visits present a special opportunity to discuss family health issues. Families may be more relaxed and willing to take the time to learn about Medicaid benefits and complete application forms. A variety of early childhood programs have a home visiting component. Some Head Start programs visit families at home; the Home Instruction Program for Preschool Youngsters (HIPPY) helps parents learn to read to their children at home; and the Child and Adult Care Food Program visits family child care providers to help plan nutritious meals and learn proper kitchen sanitation procedures.

Virginia – Child Health Investment Program *("CHIP")* of Virginia improves the health of young, low-income children by linking them with private physicians and dentists. Home visitors are the key to making this happen for more than 4,000 children currently participating in *"CHIP"* throughout the State. As *"CHIP"* home visitors develop an ongoing relationship with families, they help their families keep doctor appointments, follow through with recommended medical treatment, and obtain other services they may need. At the first *"CHIP"* visit, the home visitor finds out whether the family has Medicaid coverage. If not, the home visitor helps the family complete the State's two-page Medicaid application, which can be submitted by mail. Home visitors carry cell phones, which can come in handy for calling the Medicaid office to troubleshoot if questions arise while an application is being processed. *"CHIP"* home visitors also help families keep their coverage by assisting them with Medicaid recertification.

USE TELEPHONE RESOURCE LINES TO ENCOURAGE FAMILIES TO SEEK INFORMATION ABOUT MEDICAID AND GET CHILDREN ENROLLED

CCR&R agencies that help parents find appropriate, affordable child care, do much of their work over the telephone. During their conversations with parents, they often share information about services that families and children need other than child care. They can provide information about how to obtain Medicaid benefits and help families complete simple Medicaid applications over the telephone. Follow up calls are made in a few weeks to ensure that the process has gone smoothly or to give additional help.

Washington – Washington State's Child Care Resource and Referral Network trained telephone counselors in its 14-member CCR&Rs to screen callers for Medicaid income eligibility. The network now identifies children likely to be eligible for Medicaid and arranges for the State's Medical Assistance Administration to send families Washington's one-page Medicaid application form and basic information about the program. This form is available in seven languages and the completed form can be mailed directly to the State Medicaid agency in a pre-addressed, postage-paid envelope.

Pennsylvania – *"CHOICE"* in Philadelphia, which runs both a child care line and a health care line, goes a step further, when families who call for help in finding child care also need health insurance for their children, *"CHOICE"* telephone counselors can complete an application for either Medicaid or the State's child health insurance program while the family is on the line. Local early childhood programs also refer families to *"CHOICE"* for help in enrolling their children in Medicaid. Sometimes this help can

ensure that a child can take advantage of an open slot in a Head Start or child care program, since having Medicaid coverage can be the link to obtaining immunizations or a well-child checkup needed for Head Start enrollment.

ENLIST THE BUSINESS COMMUNITY IN PROMOTING THE MEDICAID PROGRAM

Urge local merchants to let their customers know about the availability of health insurance for children. Successful outreach campaigns have persuaded store owners to tuck flyers into children's shoe boxes, home-delivered pizza boxes, grocery bags, toys, back-to-school notebooks and book bags. Fast food restaurants can print outreach messages on place mats. Utility companies may be willing to insert information in customer bills. Businesses in your community also may have employees with children eligible for Medicaid. Raise this issue with employers whose workers enroll their children in your program. Remember that children with private insurance may use Medicaid to cover services not covered by their private plan; also, Medicaid can help make private insurance more affordable for families by assisting with premiums and other cost sharing.

Wisconsin – In an effort to provide low-income working families with information about WIC and Medicaid, Wisconsin's Outagamie County WIC Program conducts informational presentations for managers of local hotels, restaurants, and hospitals. WIC staff provides business leaders with information on Medicaid eligibility guidelines, benefits, and where to apply, as well as with materials to post and hand out to their employees. As a result of these efforts, the management of the Holiday Inn in Appleton now provides information on WIC and Medicaid to housekeeping staff. In addition, the safety committee and employee relations manager at the Ray-O-Vac battery manufacturing plant now posts information for its 150 employees through a health and safety bulletin board in each of the factory's two buildings.

MAKE SURE TRAINING PROGRAMS FOR EARLY CHILDHOOD PROGRAMS INCLUDE INFORMATION ABOUT THE AVAILABILITY OF HEALTH INSURANCE FOR CHILDREN THROUGH MEDICAID OR OTHER PROGRAMS

Many early childhood programs conduct training of one sort or another. Whether it's health and safety training for classroom staff, in-service training for providers, parenting classes for parents, there are many opportunities to incorporate information on how families can obtain health insurance.

Georgia – Georgia's *Right from the Start Medicaid Program ("RSM")* sends its 200 outreach workers into communities all over the State to find and enroll eligible pregnant women and children in Medicaid. Recently, *"RSM"* workers were invited to attend a training session for family child care providers in the Atlanta area. *RSM* workers discussed the benefits of the Medicaid program and demonstrated the easy application process. Family child care providers who are well informed about the application process - or who have been through it themselves - are in the best position to share this information with families of children in their care. Medicaid brochures and a local number to call were provided for family child care providers to share with parents of children in their care. Providers were given an opportunity to get their own children enrolled after the training.

Finally, the link between good health and learning is never so critical as in a child's early years. This is the time to nurture optimum growth and development – and to be on the lookout for any problems that require medical attention to prevent them from becoming major health concerns. Staff of early childhood programs - such as Head Start, child care centers, family child care homes, CCR&R agencies, and others have an important role to play in assuring the health of children

in their care. Parents often rely on early childhood professionals who they know and trust for advice and help in finding health care for their children. But, obtaining medical services, especially preventive care, can be difficult – or next to impossible – without health insurance.

DEFINITIONS

DEFINITIONS OF TERMS

1115 Waiver - Research and demonstration waiver for wide variety of Health and Human Services programs. For Medicaid purposes, usually used to make broad changes in eligibility, services, or the service delivery system.

Advisory Committee on Immunization Practices (ACIP) - The inter-disciplenary committee designated by Congress that determines the pediatric immunization schedule to which Vaccines for Children Program must adhere.

Capitation Rate - The fee the State Medicaid agency pays periodically to a contractor such as an HMO for each beneficiary enrolled under a contract for the provision of medical services under the State plan., whether or not the beneficiary receives the services during the period covered by the fee.

Case Management - A generic term used to describe the process of coordinating services. Case management also can be used to refer to a specific clinical monitoring and referral process.

Child Care Development Block Grant (CCDBG) - The Child Care and Development Block Grant as amended by Congress in Public Law 104-193 (Personal Responsibility and Work Opportunity Reconciliation Act) unified what was a fragmented child care system. Welfare reform repealed the welfare-connected child care programs (AFDC, JOBS, At-Risk and Transitional Child Care), and placed new child care funding under the aegis of the lead State agency for the Child Care and Development block Grant. The combined and increased funding therefore becomes part of a holistic and streamlined system for child care. The integrated funding sources consisting of both discretionary and mandatory Federal funds have a single, unified purpose. To reflect this integration of multiple funding sources, the Department of Health and Human Services has established a Child Care and Development Fund. This Fund (CCDF) supports all child care activities conducted across the country.

Child Care Resource and Referral Agency (CCR&R)- CCR&R agencies are community-based agencies with State networks and a national system of support and technical assistance. The core mission of the CCR&R field is to support families in their most important role: nurturing children while striking a healthy balance between work and family responsibilities. Promoting the health, safety and wellness of young children in child care settings is a vital part of that mission. CCR&R organizations make linkages every day among families, child care providers, schools, employers and community resources.

Federal Financial Participation - Federal dollars used to match State contributions in State administered programs such as Medicaid.

Federal Poverty Level - The phrase FPL as used in this document means the Department of Health and Human Services Poverty Guidelines which are published each year in the Federal Register. The Poverty Guidelines are the administrative version of the Federal Poverty Measure. To obtain more information about the Poverty Guidelines, you may visit the Web site on the Internet at: <<http://aspe.os.dhhs.gov//poverty/poverty.htm>>

Fee-for-service (FFS) - A service provision model in which providers bill the State Medicaid agency directly for services provided to Medicaid-eligible beneficiaries.

Health Maintenance Organization (HMO) - An entity that contracts on a prepaid, capitated risk basis to provide comprehensive health services to beneficiaries.

Individuals with Disabilities Education Act (IDEA) - Formally called the Education of the Handicapped Act, contains two parts:

> **Part B of IDEA** - designed to ensure that school-aged children with special education needs receive a free, appropriate public education. Under Part B, schools must prepare an

Individualized Education Plan (IEP) as appropriate for a child which specifies all of the special education and "related (health) services" needed by the child.

Part C of IDEA - provides for early intervention programs that include all of the available developmental services needed by a toddler or infant and the development of an Individualized Family Service Plan (IFSP). Medicaid can potentially pay for some of the health-related services in an IEP and IFSP as discussed in this guide.

Managed Care Organization (MCO) - An entity that combines the health care delivery and financing of services. The entity is generally paid a prepaid, capitated premium and assumes financial risk for the services to be provided to or arranged for enrolled beneficiaries. MCO models included fully-capitated, partially capitated and primary care case management.

State Children's Health Insurance Program (CHIP)- The Balanced Budget Act of 1997 created Title XXI of the Social Security Act, also named State Children's Health Insurance Program. Title XXI enables States to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children.

State Medicaid Agency - The organization in each State directly responsible for the administration of the Medicaid program. Each State must designate a "single State agency" for purposes of accountability to HCFA, even though a number of State (and local) agencies may help the program and/or function as medical providers.

State Plan - A document between the States and Federal government which details the scope of the Medicaid program in the State by listing the services offered, any applicable requirements and limitations and the payment rates for those services. The State plan consists of preprinted material that covers the basic requirements, and individualized content that reflects the characteristics of the particular State Medicaid program. The

State plan is submitted by the State and subject to approval from HCFA.

Supplemental Security Income (SSI) - Title XVI of the Social Security Act provides financial assistance to needy individuals who have attained age 65 or are blind or disabled.

Temporary Assistance for Needy Families (TANF) - The TANF program replaces the former Aid to Families with Dependent Children (AFDC) and JOBS programs. Under TANF, States, territories, and tribes each receive a block grant allocation to cover benefits, administrative expenses, and services; States have a maintenance of effort requirement. States, territories, and tribes determine eligibility and benefit levels and services provided to needy families.

Title IV-E - Title IV-E, Foster Care and Adoption Assistance, of the Social Security Act enables each State to provide, in appropriate cases, foster care and transitional independent living programs for children who are otherwise eligible under TANF. Funds are available for monthly payments to foster care providers on behalf of foster children; one-time payments for the costs of adopting a child as well as monthly subsidies to adoptive parents who may be income eligible for subsidies; assistance to current or former foster care youths age 16 and older to help in the transition to independent living; and administrative costs incurred by States in the administration of these programs.

Title V - Title V, Maternal and Child Health (MCH) Services Block Grant, is administered by the Health Resources and Services Administration, Public Health Service, Department of Health and Human Services. The MCH Services Block Grant program has three components: formula block grants to 59 States and Territories, Special Projects of Regional and National Significance (SPRANS) and Community Integrated Service systems (CISS) grants. These block grants enable States to create Federal and State partnerships to develop service systems in our Nation's communities to meet critical challenges in MCH.

APPENDICES

Medicaid Eligibility of Pregnant Women, Infants, and Children Effective October 1997*[1]

	Pregnant Women and Infants	Children Below Age Six	Children Ages Six and Older		Children Ages Fifteen and Older
State	Percent of FPL	Percent of FPL	Percent of FPL	Through Upper Age Limit*	AFDC Standard/ FPL on 7/16/96**
Alabama	133%	133%	100%	14	15%
Alaska	133%	133%	100%	14	76%
Arizona	140%	133%	100%	14	32%
Arkansas[a]	[133%][200%]	200%	200%	17	N/A
California	200%	133%	100%	14	82%
Colorado	133%	133%	100%	14	39%
Connecticut	185%	185%	185%	16	N/A
Delaware	185%	133%	100%	18	N/A
Florida	185%	133%	100%	14	28%
Georgia	185%	133%	100%	19	N/A
Hawaii[b]	300%	300%	300%	19	N/A
Idaho	133%	133%	100%	14	29%
Illinois	133%	133%	100%	14	46%
Indiana	150%	133%	100%	18	N/A
Iowa	185%	133%	100%	14	39%

[1]Source: Data collected by the National Governors' Association in July and August 1997.

State	Percent of FPL	Percent of FPL	Percent of FPL	Through Upper Age Limit*	AFDC Standard/ FPL on 7/16/96**
Kansas	150%	133%	100%	17	N/A
Kentucky	185%	133%	100%	14	33%
Louisiana	133%	133%	100%	18	N/A
Maine	185%	133%	125%	19	N/A
Maryland[c]	185%	185%	185%	14	34%
Massachusetts	185%	133%	133%	17	N/A
Michigan	185%	150%	150%	18	N/A
Minnesota[c]	275%	275%	275%	20	N/A
Mississippi	185%	133%	100%	14	34%
Missouri	185%	133%	100%	18	N/A
Montana	133%	133%	100%	14	41%
Nebraska	150%	133%	100%	14	34%
Nevada	133%	133%	100%	14	45%
New Hampshire	185%	185%	185%	19	N/A
New Jersey	185%	133%	100%	14	61%
New Mexico	185%	185%	185%	19	N/A
New York	185%	133%	100%	14	61%
North Carolina	185%	133%	100%	18	N/A
North Dakota	133%	133%	100%	18	N/A
Ohio	133%	133%	100%	14	32%
Oklahoma	150%	133%	100%	14	28%

State	Percent of FPL	Percent of FPL	Percent of FPL	Through Upper Age Limit*	AFDC Standard/ FPL on 7/16/96**
Oregon	133%	133%	100%	19	N/A
Pennsylvania	185%	133%	100%	14	39%
Rhode Island[c]	250%	250%	250%	17	N/A
South Carolina	185%	150%	150%	18	N/A
South Dakota	133%	133%	100%	19	N/A
Tennessee[c]	400%	400%	400%	17	N/A
Texas	185%	133%	100%	14	17%
Utah	133%	133%	100%	18	N/A
Vermont[d]	[200%][225%]	225%	225%	17	N/A
Virginia	133%	133%	100%	19	N/A
Washington[d]	[185%][200%]	200%	200%	19	N/A
West Virginia	150%	133%	100%	19	N/A
Wisconsin	185%	185%	100%	14	62%
Wyoming	133%	133%	100%	14	55%

Notes for Table: Medicaid Eligibility of Pregnant Women, Infants, and Children

N/A means not applicable.

* Under the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990), States are required to provide Medicaid coverage to children ages 6 and older born after September 30, 1983, living in families with incomes below 100 percent of the Federal poverty level (FPL). Since 1989 States have been required to cover all pregnant women, as well as children below age 6, living in families with incomes at or below 133 percent of the FPL.

** The data in this column reflects the federal minimum requirements for states for children ages fifteen and older. Federal law requires States to provide Medicaid to children if they live in families with incomes that meet the State's old Aid to Families with Dependent Children, (AFDC) income eligibility standards in effect on July 16, 1996. If a State has expanded eligibility to older children beyond the OBRA 1990 mandate, the old AFDC standard as it applies to Medicaid eligibility is not applicable. The expansion supersedes the Federal minimums that were based on the AFDC standards.

a In Arkansas pregnant women are covered at 133 percent of the FPL and infants are covered up to 200 percent of the FPL.

b Hawaii's coverage of pregnant women and children is through Hawaii QUEST, a Section 1115 waiver managed care program. Some populations receive fully subsidized services and others pay premiums. The State is considering a change in income eligibility that would take effect in late 1997. Pregnant women and infants living in families with incomes up to 185 percent of poverty would be eligible for fully subsidized Medicaid; children below age 6 living in families with incomes up to 133 percent of poverty would be eligible; and older children living in families with incomes below 100 percent of poverty would be eligible.

c Maryland, Minnesota, Rhode Island, and Tennessee operate programs under Section 1115 waivers. Some populations receive fully subsidized Medicaid services. Other populations are required to pay a portion of the premium and may have a different benefits package.

d In Vermont, pregnant women are covered at 200 percent of the FPL and infants are covered up to 225 percent of the FPL. In Washington the income eligibility criterion for pregnant women is 185 percent of poverty; the income eligibility criterion for infants is 200 percent of poverty.

Health Resources and Services Administration
Maternal and Child Health Bureau
Office of State and Community Health
Title V - Hotline List
Healthy Start 800-311-BABY

STATE	MCH 800 Numbers	STATE	MCH 800 Numbers
Alabama	800-654-1385	Montana	800-421-MOMS
Alaska	800-478-2221	Nebraska	800-862-1889
Arizona	800-833-4642	Nevada	800-862-1889
Arkansas	800-235-0002	New Hampshire	800-852-3345
California	800-222-9999	New Jersey	800-328-3838
Colorado	800-688-7777	New Mexico	800-552-8195
Connecticut	800-505-2000	New York	800-522-5006
Delaware	800-484-4357	North Carolina	800-367-2229
District of Columbia	800-MOM-BABY	North Dakota	800-472-2286
		Ohio	800-755-GROW
Florida	800-451-BABY	Oklahoma	800-42-OASIS
Georgia	800-822-2539	Oregon	800-723-3638
Hawaii	800-772-3020	Pennsylvania	800-986-2229
Idaho	800-926-2588	Puerto Rica	800-981-5567
Illinois	800-323-4769	Rhode Island	800-346-1004
Indiana	800-433-0746	South Carolina	800-868-0404
Iowa	800-369-2229	South Dakota	800-529-5000
Kansas	800-332-6262	Tennessee	800-428-BABY
Kentucky	800-462-6122	Texas	800-422-2956
Louisiana	800-251-BABY	Utah	800-826-9662
Maine	800-698-3624	Vermont	800-649-4357
Maryland	800-456-8900	Virginia	800-230-6977
Michigan	800-26-BIRTH	Washington	800-322-2588
Minnesota	NA	West Virginia	800-642-8522
Mississippi	800-721-7222	Wisconsin	800-722-2295
Missouri	800-835-5465	Wyoming	800-994-4769

REGIONAL CONTACTS

For each of the ten Federal regions, contacts are listed in the following order:

- HCFA Associate Regional Administrator
- EPSDT Regional Coordinator
- ACF Assistant Regional Administrator
- ACF Regional Child Care Liaison
- PHS Regional MCH Program Consultant

REGION I: CONNECTICUT, MAINE, MASSACHUSETTS, RHODE ISLAND, VERMONT

HCFA, Associate Regional Administrator
Division of Medicaid & State Operations
JFK Federal Building, Room 2350
Boston, MA 02203-0003
(617) 565-1223
(617) 565-1083 Fax

HCFA, MCH/EPSDT Coordinator
(617) 565-1248
(617) 565-1083 Fax

ACF, Assistant Regional Administrator
Office of Family Supportive Services
JFK Federal Building, Room 2000
Government Center
Boston, MA 02203
(617) 565-1150
(617 565-2493 Fax

ACF, Child Care Liaison
Program Specialist, Child Care Unit
JFK Federal Building, Room 2025
Government Center
Boston, MA 02203
(617) 565-1152
(617) 565-2493 Fax

PHS, MCH Program Consultant
JFK Federal Building, Room 1826
Government Center
Boston, MA 02203
(617) 565-1433
(617) 565-3044 Fax

REGION II: NEW JERSEY, NEW YORK, PUERTO RICO, VIRGIN ISLANDS

HCFA, Associate Regional Administrator
Division of Medicaid & State Operations
Room 3811
26 Federal Plaza
New York, NY 10278
(212) 264-4488
(212) 264-2580 Fax

HCFA, MCH/EPSDT Coordinator
(212) 264-3841
(212) 264-2790 Fax

ACF, Assistant Regional Administrator
Office of Family Supportive Services
Room 1243
26 Federal Plaza
New York, NY 10278
(212) 264-2974
(212) 264-4826 Fax

ACF, Child Care Liaison
Federal Building, Room 1243
26 Federal Plaza
New York, NY 10278
(212) 264-2667
(212) 264-4881 Fax

PHS, MCH Program Consultant
Federal Building, Room 3835
26 Federal Plaza
New York, NY 10278
(212) 264-2571
(212) 264-2673 Fax

Region III: Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia

HCFA, Associate Regional Administrator
Division of Medicaid & State Operations
Suite 216, The Public Ledger Building
150 S. Independence Mall West
Philadelphia, PA 19106
(215) 861-4263
(215) 861-4240 Fax

HCFA MCH/EPSDT Coordinator
(215) 861-4252
(215) 861-4240 Fax

ACF, TANF/Child Care Program Manager
Suite 864, The Public Ledger Building
150 S. Independence Mall West
Philadelphia, PA 19106-3499
(215) 861-4048
(215) 861-4070 Fax

ACF, Child Care Liaison
Suite 864, The Public Ledger Building
150 S. Independence Mall West
Philadelphia, PA 19106-3499
(215) 861-4075
(215) 861-4071 Fax

PHS, MCH Program Consultant
Health Resources, Northeast Cluster
Suite 1172, The Public Ledger Building
150 S. Independence Mall West
Philadelphia, PA 19106-3499
(215) 861-4407
(215) 861-4385 Fax

Region IV: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee

HCFA, Associate Regional Administrator
Division of Medicaid & State Operations
61 Forsyth Street, SW, 4T20
Atlanta, GA 30303-8909
(404) 562-7359
(404) 562-7483 Fax

HCFA MCH/EPSDT Coordinator
(404) 562-7410
(404) 562-7483 Fax

ACF, Director
Division of State Programs
61 Forsyth Street, SW, 4M60
Atlanta Federal Center
Atlanta, GA 30303-8909
(404) 562-2886
(404) 562-2985 Fax

ACF, Child Care Liaison
61 Forsyth Street, SW, 4M60
Atlanta Federal Center
Atlanta, GA 30303-8909
(404) 562-2892
(404) 562-2985 Fax

PHS, MCH Program Consultant
HRSA Field Coordinator, Southeast Cluster
Atlanta Federal Center
61 Forsyth Street, S. W., Suite 3M60
Atlanta, GA 30303-8909
(404) 562-7980
(404) 562-7974 Fax

Region V: Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin

HCFA, Associate Regional Administrator
Division of Medicaid & State Operations
105 West Adams Street, 15th Floor
Chicago, IL 60603-6201
(312) 353-9805
(312) 353-3419 Fax

HCFA, MCH/EPSDT Coordinator
(312) 353-8720 or (312) 353-3721
(312) 353-5927 Fax

ACF, Assistant Regional Administrator
Self Sufficiency Programs
105 West Adams Street, 21st Floor
Chicago, IL 60603
(312) 353-4439
(312) 353-2204 Fax

ACF, Child Care Liaison
105 West Adams Street, 20th Floor
Chicago, IL 60603
(312) 353-3270
(312) 353-2204 Fax

PHS, MCH Program Consultant
105 West Adams Street, 17th Floor
Chicago, IL 60603
(312) 353-4042
(312) 886-3770 Fax

Region VI: Arkansas, Louisiana, New Mexico, Oklahoma, Texas

HCFA, Associate Regional Administrator
Division of Medicaid & State Operations
1301 Young Street, Suite 833
Dallas, TX 75202
(214) 767-6301
(214) 767-0630 Fax

HCFA MCH/EPSDT Coordinator
(214) 767-6497
(214) 767-6400 Fax

ACF, Assistant Regional Administrator
Office of Family Supportive Services
10th Floor, 1200 Main Tower Bldg..
Dallas, TX 75202
(214) 767-9648
(214) 767-3743 Fax

ACF, Child Care Liaison
Program Manager
1200 Main Tower, Suite 1050
Dallas, TX 75202-4348
(214) 767-6236
(214) 767-4155 Fax

PHS, MCH Program Consultant
MCH/Family Planning Branch
1301 Young Street, 10th Floor, HRSA-4
Dallas, TX 75202
(214) 767-3003
(214) 767- 8049 Fax

Region VII: Iowa, Kansas, Missouri, Nebraska

HCFA, Associate Regional Administrator
Division of Medicaid & State Operations
Richard Bolling Federal Building
601 East 12th Street, Room 227
Kansas City, MO 64106-2808
(816) 426-5925 ext. 3301
(816) 426-3851 Fax

HCFA, MCH/EPSDT Coordinator
(816) 426-3406
(816) 426-3851 Fax

ACF, Assistant Regional Administrator
State & Tribal Operations
601 East 12th Street, Room 276
Federal Building
Kansas City, MO 64106
(816) 426-3981
(816) 426-2888 Fax

ACF, Child Care Liaison
601 East 12th Street, Room 276
Federal Building
Kansas City, MO 64106
(816) 426-5401 ext. 184
(816) 426-2888 Fax

PHS, MCH Program Consultant
Federal Building, Room 501
601 East 12th Street
Kansas City, MO 64106-2808
(816) 426-5292
(816) 426-3633 Fax

Region VIII: Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming

HCFA, Associate Regional Administrator
Division of Medicaid & State Operations
Federal Office Building, Room 522
1961 Stout Street
Denver, CO 80294-3538
(303) 844-4024 ext. 426
(303) 844-3753 Fax

HCFA MCH/EPSDT Coordinator
(303) 844-4024 or (303) 844-2121 ext. 454
(303) 844-3753 Fax

ACF, Regional Administrator
Room 924, Federal Office Building
1961 Stout Street
Denver, CO 80294
(303) 844-3106
(303) 844-3642 Fax

ACF, Child Care Liaison
1961 Stout Street, Room 924
Denver, CO 80294
(303) 844-3100 ext. 374
(303) 844-2624 Fax

PHS, MCH Program Consultant
Federal Office Building, Room 1189
1961 Stout Street
Denver, CO 80294
(303) 844-3204
(303) 844-0002 Fax

REGION IX: AMERICAN SAMOA, ARIZONA, CALIFORNIA, GUAM, HAWAII, NEVADA, NORTHERN MARIANAS ISLANDS

HCFA, Associate Regional Administrator
Division of Medicaid & State Operations
75 Hawthorne Street
4th and 5th Floors
San Francisco, CA 94105-3903
(415) 744-3571
(415) 744-2933 Fax

HCFA MCH/EPSDT Coordinator
(415) 744-3579
(415) 744-2933 Fax

ACF, Assistant Regional Administrator
Office of Family Supportive Services
Federal Building, Room 465
50 United Nations Plaza
San Francisco, CA 94102
(415) 566-1039
(415) 556-3046 Fax

ACF, Child Care Liaison
Federal Office Building, Room 450
50 United Nations Plaza
San Francisco, CA 94102
(415) 437-8421
(415) 437-8436 Fax

PHS, MCH Program Consultant
Federal Office Building, Room 317
50 United Nations Plaza
San Francisco, CA 94102
(415) 437-8101
(415) 437-8105 Fax

REGION X: ALASKA, IDAHO, OREGON, WASHINGTON

HCFA, Associate Regional Administrator
Division of Medicaid & State Operations
2201 Sixth Avenue, MS/RX-43
Seattle, WA 98121-2500
(206) 615-2334
(206) 615-2435 Fax

HCFA MCH/EPSDT Coordinator
(206) 615-2400
(206) 615-2435 Fax

ACF, Assistant Regional Administrator
Office of Family Supportive Services
2201 6th Avenue, Mail Stop RX 32
Seattle, WA 98121
(206) 553-2430
(206) 553-0421 Fax

ACF, Child Care Liaison
CCWD & Y Branch
2201 6th Avenue, Suite 600
Seattle, WA 98121-1827
(206) 615-2552 ext. 3097
(206) 615-2575 Fax

PHS, MCH Program Consultant
Mail Stop RX-27
2201 6th Avenue, Room 700
Seattle, WA 98121
(206) 615-2518
(206) 615-2500 Fax

STATE, TERRITORY & TRIBE CONTACTS

For Each State and Territory Contacts are Listed in the Following Order:

- State Medicaid Director
- State EPSDT Coordinator
- State Maternal and Child Health Director
- State Coordinator for Children with Disabilities
- State Child Care and Development Fund Contact
- **Tribal Child Care & Development Fund Contact

For information about State Child Care Resource and Referral Agencies, contact the National Association of Child Care Resource and Referral Agencies, 1319 F Street, NW, Suite 810, Washington, DC 20004. Telephone: (202) 393-5501 - Fax: (202) 393-1109

ALABAMA

Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
P. O. Box 5624
Montgomery, AL 36103-5624
(334) 242-5600
(334) 242-5097 Fax

EPSDT Coordinator
(334) 242-5050
(334) 242-0057 Fax

Director
Bureau of Family Health Services
Alabama Department of Public Health
201 Monroe Street, PO Box 303017
Montgomery, AL 36130-3017
(334) 206-5675
(334) 206-2950 Fax

Director
Children's Rehabilitative Services
Alabama Department
of Rehabilitation Services
2129 East South Boulevard, P.O. Box 11586
Montgomery, AL 36111-0586
(334) 281-8780
(334) 281-1973 Fax

Office of Child Care Licensing & Regulations
Alabama Department of Human Resources
50 Ripley Street
Montgomery, AL 36130
(334) 242-1425
(334) 242-0939 Fax

**Social Service Director
Poarch Band of Creek Indians
HCR 69A Box 85B
5811 Jacks Springs Road
Atmore, AL 36502
(334) 368-9136
(334) 368-4502 Fax

ALASKA

Director
Department of Health & Social Services
Division of Public Assistance
10002 Glacier Highway, Suite 201
Juneau, AK 99801
(907) 465-3551
(907) 465-5238 Fax

EPSDT Coordinator
(907) 465-2845
(907) 465-8698 Fax

Section Chief
Alaska Department of Health & Social Services
1231 Gambell Street
Anchorage, AK 99501-4627
(907) 269-3400
(907) 269-3414 Fax

Unit Manager Special Needs Services
Alaska Department of Health & Social Services
1231 Gamball Street
Anchorage, AK 99501-4627
(907) 269-3400
(907) 269-3465 Fax

Department of Health & Social Services
Division of Public Assistance
P. O. Box 110640
Juneau, AK 99811-0640
(907) 465-5842
(907) 465-5154 Fax

**Arctic Slope Native Association
P.O. Box 1232
Barrow, AK 99723-1232
(907) 852-2762
(907) 852-2049 Fax

**President - CEO
Kuigpagmiut
P.O. Box 32209
Mountain Village, AK 99632
(907) 591-2834
(907) 591-2109 Fax

**President
Mt. Sanford Tribe
P.O. Box 357
Gakona, AK 99586
(907) 822-9366
(907) 822-9319 Fax

**Yakutat Tlingit Tribe
P.O. Box 418
Yakutat, AK 99689
(907) 784-3238
(907) 784-3595 Fax

**Sitka Tribe of Alaska
456 Katlian Street
Sitka, AK 99835-7505
(907) 747-3207
(907) 747-4915 Fax

**Orutsararmuit Indian Tribe
P.O. Box 927
Bethel, AK 99559
(907) 543-2608
(907) 543-5929 Fax

**Director
Metlakatla Indian Community
P.O. Box 8
Metlakatla, AK 99926
(907) 886-5872
(907) 886-7997 Fax

**Education Administrator
Kodiak Area Native Association
3449 East Rezanof Drive
Kodiak, AK 99615-6928
(907) 486-9800
(907) 486-9898 Fax

**Akiachak Native Community
P.O. Box 70
Akiachak, AK 99551
(907) 825-4065
(907) 825-4029 Fax

**Bristol Bay Native Association
P.O. Box 310
Dillingham, AK 99576
(907) 842-4139
(907) 842-4106 Fax

**Association of Village Council Presidents
P.O. Box 219
Bethel, AK 99559
(907) 543-3159
(907) 543-3596 Fax

**Kivalina I.R.A. Council
P.O. Box 50051
Kivalina, AK 99750
(907) 645-2201
(907) 645-2193 Fax

**Native Village of Barrow
P.O. Box 1139
Barrow, AK 99723
(907) 852-4411
(907) 543-3159 Fax

**Central Council of the Tlingit and Haida Indian Tribes of Alaska
320 W. Willoughby Avenue, Suite 300
Juneau, AK 99801-9983
(907) 463-7134
(907) 586-8970 Fax

**Chugachmiut
4201 Tudor Center Drive, Suite 210
Anchorage, AK 99503
(907) 562-4155
(907) 563-2891 Fax

**Akiak Native Community
P.O. Box 185
Akiak, AK 99552
(907) 765-7112
(907) 765-7512 Fax

**Cook Inlet Tribal Council
Family Services Department
670 W. Fireweed Lane, Suite 220
Anchorage, AK 99503
(907) 265-5915
(907) 265-5948 Fax

**Aleutian/Pribilof Islands Association
401 E. Fireweed Lane, Suite 201
Anchorage, AK 99503-2111
(907) 276-2700
(907) 258-3514 Fax

**Tanana Chiefs Conference, Inc.
Family Services
122 First Avenue, Suite 600
Fairbanks, AK 99701-4897
(907) 452-8251
(907) 459-3851 Fax

**Kenaitze Indian Tribe
P.O. Box 988
Kenai, AK 99611
(907) 283-3633
(907) 283-3052 Fax

**Executive Director
Maniilaq Manpower, Inc.
P.O. Box 725
Kotzebue, AK 99752
(907) 442-3860
(907) 442-2003 Fax

**Native Villiage of Point Hope
P.O. Box 109
Point Hope, AK 99766
(907) 368-2330
(907) 368-2332 Fax

**Program Coordinator
Agdaagux Tribal council
P.O. Box 18
King Cove, AK 99612-0018
(907) 497-2648
(907) 497-2803 Fax

**Copper River Native Association
Drawer H
Copper Center, AK 99573
(907) 822-5241
(907) 822-3041 Fax

AMERICAN SAMOA

Medicaid Program Director
Department of Health
LBJ Tropical Medical Center
Pago Pago, AS 96799
(684) 633-4590
(684) 633-1869 Fax

EPSDT Coordinator
Same As Above

Director
Public Health Services
American Samoa Government
Pago Pago, AS 96799
(684) 633-4606
(684) 633-5379 Fax

American Samoa Government
Same As Above

Social Services Division
Department of Human Resources
American Samoa Government
Pago Pago, AS 96799
Telephone and Fax Nos. Not Available

ARIZONA

Director
Arizona Health Care Cost
Containment System (AHCCCS)
801 East Jefferson Street
Phoenix, AZ 85034
(602) 417-4000 ext. 4680
(602) 252-6536 Fax

EPSDT Coordinator
(602) 417-4241
(602) 254-1769 Fax

Chief
Office of Women's & Children Health
Arizona Department of Health Services
411 N. 24th Street, Birch Hall
Phoenix, AZ 85008
(602) 220-6550
(602) 220-6551 Fax

Chief
Office of Children with Special
Health Care Needs
Arizona Department of Health Services
1740 W. Adams, Room 200
Phoenix, AZ 85007
(602) 220-6572
(602) 542-2589 Fax

Program Manager
Child Care Administration
Arizona Department of Economic Security
P.O. Box 6123
Phoenix, AZ 85005-6123
(602) 542-4248
(602) 542-4197 Fax

**CCDBG Coordinator
San Carlos Apache Tribe
P.O. Box 0
San Carlos, AZ 85550
(520) 475-2703
(520) 475-2507 Fax

**Director
Fort McDowell Mohave-Apache Indian
Community
P.O. Box 17779
Fountain Hills, AZ 85269-7779
(602) 837-3970 ext. 250
(602) 837-4441 Fax

**Child Care Coordinator
White Mountain Apache Tribe
P.O. Box 520
Whiteriver, AZ 85941
(520) 338-4818
(520) 338-1039

**Child Care & Development Services
Gila River Indian Community
P.O. Box 97
Sacaton, AZ 85247
(520) 562-3640
(520) 562-3348 Fax

**Child Care Director
Navajo Nation
P.O. Box 4590
Window Rock, AZ 86515
(520) 871- 6827
(520) 871-6278 Fax

**Pascua Yaqui Tribe
Social Services Department
7474 S. Camino De Oeste
Tucson, AZ 85746
(602) 883-5060
(602) 883-5014 Fax

**Child Care Coordinator
Yavapai-Apache Tribe
P.O. Box 1188
Camp Verde, AZ 86322
(602) 567-3649
(602) 567-3994 Fax

**CCDBG Coordinator
Hopi Tribe
P.O. Box 123
Kykotsmovi, AZ 86039
(520) 734-2441 ext. 432
(520) 734-2435 Fax

**CCDBG Coordinator
Cocopah Indian Tribe
County 15 & Avenue G
Somerton, AZ 85350
(520) 627-2927
(520) 627-4949 Fax

**Salt River Pima-Maricopa
Indian Community
Route 1, Box 216
Scottsdale, AZ 85256-9722
(602) 874-8071
(602) 874-8091 Fax

**Day Care Coordinator
Tohono O'Odham Nation
P.O. Box 837
Sells, AZ 85634
(520) 383-2221 ext. 258
(520) 383-2429 Fax

**Child Care Director
Quechan Indian Tribe
Fort Yuma Indian Reservation
P.O. Box 11352
Yuma, AZ 85366-9352
(619) 572-2480
(619) 572-2102 Fax

**Hualapai Child Care Program
P. O. Box 179
Peach Springs, AZ 86434
(520) 769-2216
(520) 769-2653 Fax

ARKANSAS

Director
Division of Medical Services
Department of Human Services
P. O. Box 1437, Slot 1100
Little Rock, AR 72203-1437
(501) 682-8292
(501) 682-8013 Fax

EPSDT Coordinator
(501) 682-8297
(501) 682-8304 Fax

Medical Director
Section of Maternal & Child Health
Arkansas State Department of Health
4815 West Markham, Slot 41
Little Rock, AR 72205-3867
(501) 661-2199
(501) 661-2055 Fax

Program Director
Arkansas Department of Human Services
Children's Medical Service
P.O. Box 1437, Slot 526
Little Rock, AR 72203
(501) 682-1464
(501) 682-8247 Fax

Division of Children & Family Services
Arkansas Department of Human Services
Main Street Mall
P. O. Box 1437- Slot 604
Little Rock, AR 72203-1437
(501) 682-8947
(501) 682-2317 Fax

CALIFORNIA

Deputy Director
Medical Care Services
Department of Health Services
714 P Street, Room 1253
Sacramento, CA 95814
(916) 654-0391
(916) 657-1156 Fax

EPSDT Coordinator
(916) 657-1460
(916) 657-0957 Fax

Branch Chief
Maternal & Child Health Branch
California State Department
of Health Services
714 P Street, Room 750
Sacramento, CA 95814
(916) 657-1347
(916) 657-3069 Fax

Chief
Children Services Branch
California State Department
of Health Services
714 P Street, Room 398
Sacramento, CA 95814
(916) 654-0499
(916) 653-4892 Fax

Child Development Division
California State Department of Education
560 J Street, Suite 220
Sacramento, CA 95814
(916) 322-4240
(916) 323-6853 Fax

**Tribal Administrator
Enterprise Rancheria
2950 Feather River Boulevard
Oroville, CA 95965-9643
(916) 532-9214
(916) 532-1768 Fax

**Acting, CCDBG Coordinator
Karuk Tribe of California
P.O. Box 1016
Happy Camp, CA 96039
(916) 493-5305
(916) 493-5322 Fax

**Administrator
Hopland Band of Pomo Indians
P.O. Box 610
Hopland, CA 95449
(707) 744-1647
(707) 744-1506 Fax

**CCDBG Coordinator
La Jolla Indian Reservation
Star Route, Box 158
Valley Center, CA 92082
(619) 742-3771
(619) 742-1704 Fax

**Community Health Rep/Day Care
Pit River Tribe
36977 Park Avenue
Burney, CA 96013
(916) 335-5421
(916) 335-3140 Fax

**CCDBG Coordinator
Yurok Tribe
15900 Highway 101
Klamath, CA 95548
(707) 482-2921
(707) 482-9465 Fax

**CCDBG Coordinator
Soboba Band of Mission Indians
P.O. Box 487
San Jacinto, CA 92383
(909) 654-2765
(909) 654-4198 Fax

**Fort Mojave Indian Tribe
500 Merriman Avenue
Needles, CA 92363
(619) 326-4591
(619) 326-2468 Fax

**Tribal Administrator
Scotts Valley Band of Pomo Indians
149 N. Main Street, Suite 200
Lakeport, CA 95453
(707) 263-4771
(707) 263-4773 Fax

**Tribal Administrator
Mechoopda Indian Tribe of Chico Rancheria
1907 Mangrove Avenue, Suite F
Chico, CA 95926-2381
(916) 899-8922
(916) 899-8517 Fax

**Tribal Administrator
Round Valley Indian Tribes
P.O. Box 448
Covelo, CA 95428
(707) 983-6126
(707) 983-6128 Fax

**Southern California Tribal
Chairman's Association, Inc.
P.O. Box 1470
Valley Center, CA 92082
(619) 749-0910
(619) 749-5615 Fax

**Pauma Band of Mission Indians
P.O. Box 86
Pauma Valley, CA 92061
(619) 742-1289
(619) 742-3422 Fax

**Project Director
Tyme Maidu of the Berry Creek Rancheria
5 Tyme Way
Oroville, CA 95966
(916) 325-5673
Fax Number Unavailable

**Tribal Administrator
Rincon Indian Reservation
P.O. Box 68
Valley Center, CA 92082
(619) 749-1051
(619) 749-8901 Fax

**CCDBG Coordinator
Mooretown Rancheria
1 Alverda Drive
Oroville, CA 95966-9379
(916) 533-3625
(916) 533-3680 Fax

**Tribal Administrator
Chukchansi Tribe of the Picayune
P.O. Box 269
Coarsegold, CA 93614
(209) 683-6633
(209) 683-0599 Fax

**California Indian Manpower Consortium
4153 Northgate Boulevard
Sacramento, CA 95834
(916) 925-3582
(916) 641-6338 Fax

**CCDBG Coordinator
Agua Caliente Band of Cahuilla Indians
P.O. Box 1291
Yucca Valley, CA 92286
(619) 325-5673
(619) 325-0593 Fax

**Tribal Administrator
Rohnerville Rancheria
Bear River Mattole Wiyot Tribe
P.O. Box 731
Loleta, CA 95551
(707) 733-1900
(707) 733-1972 Fax

**CCDBG Coordinator
California Rural Indian Health Board, Inc.
1451 River Park Drive
Sacramento, CA 95815
(916) 929-9761
(916) 929-7246 Fax

**CCDBG Coordinator
Torres Martinez Desert Cahuilla Indians
P.O. Box 1160
Thermal, CA 92274
(619) 397-8144
(619) 397-8146 Fax

**Pala Band of Mission Indians
P.O. Box 43
Pala, CA 92059
(619) 742-4619
(619) 742-1411 Fax

**Hoopa Tribal Education Association
P.O. Box 428
Hoopa, CA 95546
(916) 625-4413
(916) 625-5444 Fax

**Director
Inter-tribal Council of California
2755 Cottage Way, Suite 14
Sacramento, CA 95825-1221
(916) 973-9581
(916) 973-0117 Fax

**Executive Director
Lytton Rancheria
1250 Coddingtown Center, Suite 1
Santa Rosa, CA 95401
(707) 575-5917
(707) 575-6974 Fax

**Administrative Assistant
Colverdale Rancheria
2013 Longleaf Court
Santa Rosa, CA 95403
(707) 523-3882
(707) 523-1230 Fax

**Tribal Administrator
Pinoleville Indian Reservation
367 N. State Street, Suite 204
Ukiah, CA 95482
(707) 463-1454
(707) 463-6601 Fax

**Tribal Administrator
North Fork Rancheria
P.O. Box 929
North Fork, CA 93643
(209) 877-2461
(209) 877-2467 Fax

**CCDBG Coordinator
Campo Seven Trive Consortium
36910 Church Road, Suite 1
Campo, CA 91906
(619) 445-1188
(619) 445-4131 Fax

**Interim Head Start Director
Morongo Band of Mission Indians
11581 Potrero Road
Banning, CA 92220-2965
(909) 849-1291
(909) 849-7402 Fax

**Social Services Director
Table Bluff Reservation
Wiyot Tribe
P.O. Box 519
Loleta, CA 95551
(707) 733-5055
(707) 733-5601 Fax

**CCDBG Administrator
Greenville Rancheria
645 Antelope Boulevard, Suite 15
Red Bluff, CA 96080-2465
(919) 529-7166
(919) 528-9002 Fax

**Bishop Paiute Tribe
P.O. Box 1648
Bishop, CA 93514
(619) 873-5740
(619) 873-4143 Fax

**CCDBG Program Administrator
Redding Rancheria
2000 Redding Rancheria Road
Redding, CA 96001
(916) 255-8979 ext. 133
(916) 241-1879 Fax

**Social Services Director
Quartz Valley Indian Reservation
P.O. Box 24
11219 N. Highway 3, Suite J
Fort Jones, CA 96032
(916) 468-5937
(916) 468-2491 Fax

**CCDBG Coordinator
Susanville Indian Reservation
795 Joaquin Street
Susanville, CA 96130-1719
(916) 257-2542
(916) 257-6983 Fax

COLORADO

Director
Office of Medical Assistance
Department of Health Care
Policy & Financing
1575 Sherman Street - Fourth Floor
Denver, CO 80203-1714
(303) 866-2859
(303) 866-2803 Fax

EPSDT Coordinator
(303) 866-5532
(303) 866-2573 Fax

Director
Family & Community Health
Services Division
Colorado Department of Public Health
& Environment
4300 Cheery Creek Drive South
Denver, CO 80246-1530
(303) 692-2302
(303) 753-9249 Fax

Director
Health Care Program, CSN
CO Department of Public
Health & Environment
4300 Cherry Creek Drive South
Denver, CO 80246-1530
(303) 692-2389
(303) 782-5576 Fax

Director
Colorado Department of Human Services
Division of Child Care
1575 Sherman Street, 1st Floor
Denver, CO 80203-1714
(303) 866-5958
(303) 866-4453 Fax

**Child Care Coordinator
Southern Ute Indian Tribe
P.O. Box 737
116 Capote Drive
Ignacio, CO 81137
(970) 563-0100 ext. 328
(970) 563-0396 Fax

**Child Care Coordinator
Ute Mountain Ute Tribe
Ute Mountain Reservation
Tribal Social Services
P.O. Box 248
Towaoc, Co 81334
(970) 565-3751 ext. 270
(970) 565-2733 Fax

CONNECTICUT

Deputy Commissioner
Administration
Connecticut Department of Social Services
25 Sigourney Street
Hartford, CT 06106-5033
(860) 424-5598
(860) 424-2996 Fax

EPSDT Coordinator
(860) 424-5229
(860) 424-4958 Fax

Title V & CSHCN
Director Family Health
CT Department of Public Health
Services
P.O. Box 340308,
410 Capitol Ave., MS 11FHS
Hartford, CT 06134-0308
(860) 509-8066
(860) 509-7720 Fax

Supervisor
MCH & CSHCN
Connecticut Department of Public
Health Services
P.O. Box 340308
410 Capitol Ave., MS 11 MAT
Hartford, CT 06134-0308
(860) 509-8081
(860) 509-7720 Fax

Office of Child Care
Connecticut Department of Social Services
25 Sigourney Street, 10th Floor
Hartford, CT 06106-5033
(860) 424-5598
(860) 951-2996 Fax

DELAWARE

Medicaid Director
Department of Health & Social Services
1901 North DuPont Highway
New Castle, DE 19720
(302) 577-4901
(302) 577-4899 Fax

EPSDT Coordinator
(302) 577-4900 ext. 144
(302) 577-4899 Fax

Director
Delaware Division of Public Health
P.O. Box 637
Dover, DE 19903
(302) 739-3111
(302) 739-6656 Fax

Director
Northern Health Services
Delaware Division of Public Health
Child Development Watch
2055 Limestone Road, Suite 215
Wilmington, DE 19808
(302) 995-8576
(302) 995-8616 Fax

Delaware Department of Health &
Social Services
Lewis Building
P.O. Box 906
New Castle, DE 19720
(302) 577-4400
(302) 577-4405 Fax

WASHINGTON, D.C.

Commissioner
Commission on Health Care Finance
Department of Health
2100 ML King, Jr., Avenue, SE
Suite 302
Washington, DC 20020
(202) 727-0735
(202) 610-3209 Fax

EPSDT Coordinator
(202) 727-0725
(202) 610-3209 Fax

DC Healthy Start
800 9th Street, SW, 3rd Floor
Washington, DC 20024
(202) 645-5620
(202) 645-0525 Fax

Project Area Coordinator
DC Healthy Start
2700 MLK Jr., Ave., SE, Cottage #7
Washington, DC 20032
(202) 645-4178
(202) 562-5084 Fax

Office of Early Childhood Development
Commission on Social Service
DC Dept. Of Human Services
717 14th Street, NW #730
Washington, D.C. 20005
(202) 727-1839
(202) 727-9709 Fax

FLORIDA

Director of Medicaid
Agency for Health Care Administration
P.O. Box 13000
Tallahassee, FL 32317-3000
(850) 488-3560
(850) 488-2520 Fax

EPSDT Coordinator
(850) 922-7321
(850) 922-7303 Fax

Chief
Department of Health
Family Health Services
Bureau of Child, Family & Community Health
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
(850) 487-1321
(850) 414-6091 Fax

Assistant Division Director for CMS
Department of Health, CMS
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
(850)-487-2690
(850)-488-3813 Fax

Chief of Child Care Services
Children & Families
1317 Winewood Boulevard
Bldg. 7, Room 228
Tallahassee, FL 32399-0700
(850) 488-4900
(850) 488-9584 Fax

**Head Start Director
Miccosukee Corporation
P.O. Box 440021
Tamiami Station
Miami, FL 33144-0021
(305) 223-8380
(305) 223-1011 Fax

**Pre-school Program Director
Seminole Tribe of Florida
6073 Stirling Road
Hollywood, FL 33024
(305) 962-1866
(305) 966-2809 Fax

GEORGIA

Commissioner
Department of Medical Assistance
2 Peachtree Street, NW
40th Floor, Suite 4043
Atlanta, GA 30303-3159
(404) 656-4479
(404) 651-6880 Fax

EPSDT Coordinator
(404)-656-4135
(404)-651-9496 Fax

Director
Family Health Branch
Georgia Department of Human Resources
2 Peachtree Street, NW, Suite 8-113
Atlanta, GA 30303
(404) 657-2850
(404) 657-7307 Fax

Director
Child & Adolescent Health
Georgia Department of Human Resources
2600 Skyland Drive, NE, Lower Level
Atlanta, GA 30319
(404) 679-0547
(404) 679-0537 Fax

DFCS Family Support Unit
Georgia Department of Human Resources
2 Peachtree Street, NW, Room 12-400
Atlanta, GA 30303
(404) 657-3438
(404) 657-3489 Fax

GUAM

Administrator
Bureau of Health Care Financing
Department of Public Health &
Social Services
P.O. Box 2816
Agana, GU 96910
(671) 735-7264 or 7269
(671) 734-6860 Fax

EPSDT Coordinator
Same As Above

Acting Administrator
MCH/CSHCN Contact
Bureau of Family Health &
Nursing Services
Department of Public Health &
Social Services
P.O. Box 2816
Agana, GU 96910
(671) 734-7116
(671) 734-7097 Fax

Guam Department of Public Health &
Social Services
Government of Guam
P. O. Box 2816
Agana, GU 96910
(671) 735-7285
(671) 734-5910 Fax

HAWAII

Administrator
Med QUEST Division
Department of Human Services
P. O. Box 339
Honolulu, HI 96809-0339
(808) 586-5391
(808) 586-5389 Fax

EPSDT Coordinator
(808) 586-5411
(808) 586-5389 Fax

Chief
Family Health Services Division
Hawaii State Department of Health
1250 Punchbowl Street, Room 216
Honolulu, HI 96813
(808) 586-4122
(808) 586-9303 Fax

Chief
CSHCN Branch
Hawaii State Department of Health
741 Sunset Avenue
Honolulu, HI 96816
(808)-733-9070
(808)-733-9068 Fax

Division Administrator
Hawaii Department of Human Services
Benefit Employment & Support Services Division
Child Care Program Office
1001 Bishop Street, Pacific Tower
Suite 900
Honolulu, HI 96813
(808) 586-7050
(808) 586-5180 Fax

IDAHO

Administrator
Division of Medicaid
Department of Health & Welfare
Towers Building - Second Floor
P. O. Box 83720
Boise, ID 83720-0036
(208) 334-5747
(208) 332-7342 Fax

EPSDT Coordinator
(208) 334-5795
(208) 334-0657 Fax

Chief
Bureau of Clinical & Preventive Services
ID Department of Health & Welfare
450 W State Street, P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5930
(208) 332-7346 Fax

Manager
Children's Special Health Program
ID Department of Health & Welfare
450 W State Street, P.O. Box 83720
Boise, ID 83720-0036
(208) 334-5963
(208) 334-6581 Fax

Child Care Coordinator
Division of Welfare
Department of Health & Welfare
450 West State Street, 6th Floor
P. O. Box 83720
Boise, ID 83720-0036
(208) 334-5733
(208) 334-5817 Fax

**Northwestern Band of the Shoshone Nation
P.O. Box 637
Blackfoot, ID 83221
(208) 785-7401
(208) 785-2206 Fax

**Nez Perce Tribe
P.O. Box 365
Lapwai, ID 83540-0365
(208) 843-7330
(208) 843-2036 Fax

**Executive Director
Shoshone-Bannock Tribes
P.O. Box 306
Fort Hall, ID 83203
(208) 238-3700
(208) 237-3987 Fax

**Child Care Coordinator
Coeur D'alene Tribes
850 A Street
P.O. Box 408
Plummer, ID 83851-0408
(800) 825-2202
(208) 686-1182 Fax

ILLINOIS

Administrator
Medical Programs Division
Department of Public Aid
201 South Grand Avenue, East
Third Floor
Springfield, IL 62763-0001
(217) 782-2570
(217) 782-5672 Fax

EPSDT Coordinator
(217) 524-7107
(217) 524-7535 Fax

Associate Director
Office of Family Health
Illinois Department of Human Services
535 West Jefferson Street, 1st Floor
Springfield, IL 62761
(217) 782-2736
(217) 557-2595 Fax

Interim Director
Division of Specialized Care for Children
University of Illinois at Chicago
2815 W Washington Street, Suite 300
P.O. Box 19481
Springfield, IL 62794-9481
(217) 793-2340
(217) 793-0773 Fax

Chief
Office of Child Development
Department of Children & Family Services
406 East Monroe Street, Station 55
Springfield, IL 62701-1498
(217) 524-2480
(217) 785-2454 Fax

INDIANA

Assistant Secretary
Family & Social Services Administration
Office of Medicaid Policy & Planning
Room W382
402 W. Washington Street
Indianapolis, IN 46204-2739
(317) 233-4455
(317) 232-7382 Fax

EPSDT Coordinator
(317) 232-4328
(317) 232-7382 Fax
Medical Director
CSHCS/MCH/WIC
Indiana State Department of Health
2 North Meridian Street, Suite 700
Indianapolis, IN 46204
(317) 233-1240
(317) 233-1299 Fax

Director
CSHCS/MCH/WIC
Indiana State Department of Health
2 North Meridian Street, Suite 700
Indianapolis, IN 46204
(317) 233-5578
(317) 233-5609 Fax

Deputy Director
Bureau of Child Development
Indiana Family & Social Services
Administration
402 W. Washington Street, Room. W386
Indianapolis, IN 46204
(317) 232-1144
(317) 232-7948 Fax

IOWA

Administrator
Division of Medical Services
Department of Human Services
Hoover State Office Building
Fifth Floor
Des Moines, IA 50319
(515) 281-8621
(515) 281-7791 Fax

EPSDT Coordinator
(515) 281-5796
(515) 281-4597 Fax

Bureau Chief
Family Services
Iowa Department of Public Health
Lucas Building, 3rd Floor
Des Moines, IA 50319-0075
(515) 281-4911
(515) 242-6384 Fax

Director
Child Health Specialty Clinics
Iowa University Hospitals & Clinics
100 Hawkins Drive, Room 247 Services
Iowa City, IA 52242-1011
(319) 356-1118
(319) 356-3715 Fax

Chief
Bureau of Individual & Family
Support Services
Iowa Department of Human Services
Hoover State Office Building--5th Floor
Des Moines, IA 50319-0114
(515) 281-3186
(515) 281-4597 Fax

KANSAS

Commissioner
Adult Medical Services
Department of Social &
Rehabilitation Services
Docking State Office Building
Room 628 South
915 SW Harrison Street
Topeka, KS 66612
(785) 296-3981
(785) 296-4813 Fax

EPSDT Coordinator
(913) 296-4750
(913) 296-4813 Fax

Director
Bureau for Children Youth & Family
Kansas Department of
Health & Environment
900 SW Jackson, 10th Floor, 1052, LSOB
Topeka, KS 66612-1290
(785) 296-1310
(785) 296-8626 Fax

Director
Services for CSHCN
Kansas Department of Health
& Environment
900 SW Jackson, 1005N, LSOB
Topeka, KS 66612-1290
(785) 296-1316
(785) 296-8616 Fax

Administrator
Child Care Services
Kansas Department of Social &
Rehabilitative Services
915 SW Harrison
Docking State Office Building
Room 651W
Topeka, KS 66612
(913) 296-3374
(913) 296-0146 Fax

**CCDBG Coordinator
Prairie Band of Potawatomi Indians
Route 2 , Box 50A
Mayetta, KS 66509
(913) 966-2577
(913) 966-2144 Fax

**CCDBG Coordinator
Kickapoo Tribe of Kansas
Child Care Services Program
P.O. Box 271
Horton, KS 66439-0271
(913) 486-2994
(913) 486-2801 Fax

KENTUCKY

Commissioner
Department for Medicaid Services
Forth Floor
275 East Main Street
Frankfort, KY 40601
(502) 564-7130
(502) 564-3866 Fax

EPSDT Coordinator
(502) 564-6890
(502) 564-3232 Fax

Director
Division of MCH
Department for Health Services
275 East Main Street, 2nd Floor, HSB
Frankfort, KY 40601
(502) 564-4830
(502) 564-8389 Fax

Executive Director
Commission for CSHCN
982 Eastern Parkway
Louisville, KY 40217
(502) 595-4459 ext. 267
(502) 595-4673 Fax

Branch Manager
Division of Program Management
Department of Social Services
Cabinet for Families & Children
275 East main Street, 6th Floor West
Frankfort, KY 40621
(502) 564-6750
(502) 564-2467 Fax

LOUISIANA

Director
Bureau of Health Services Financing
Department of Health & Hospitals
P. O. Box 91030
Baton Rouge, LA 70821-9030
(504) 342-3891
(504) 342-3893 Fax

EPSDT Coordinator
(504) 342-3928
(504) 342-3893 Fax

Administrator
MCH Section
DHH-Office of Public Health
P.O. Box 60630
New Orleans, LA 70160
(504) 568-5073
(504) 568-8162 Fax

Administrator
MCH Section
DHH-Office of Public Health
P.O. Box 60630
New Orleans, LA 70160
(504) 568-5055
(504) 568-7529 Fax

Administrator
Louisiana Department of Social Services
Child Care Assistance Program
State Office
P.O. Box 91193
Baton Rouge, LA 70821-9193
(504) 342-9108
(504) 342-9111 Fax

**Tribal Planner
Tunica Biloxi Indian Tribe
P.O. Box 331
Markville, LA 71351
(318) 253-5100
(318) 253-9791 Fax

**Coushatta Tribe of Louisiana
P.O. Box 818
Elton, LA 70532
(318) 584-2661
(318) 584-2998 Fax

MAINE

Director
Bureau of Medical Services
Department of Human Services
249 Western Avenue
Augusta, ME 04333
(207) 287-3094 or 1 (800) 321-5557
(207) 287-2675 Fax

EPSDT Coordinator
(207) 287-3794
(207) 287-2675 Fax

Director
Family Health
Department of Human Services
Division of Community & Family Health
11 State House Station
Augusta, ME 04333-0011
(207) 287-9917
(207) 287-4631 Fax

Director
Coordinated Care Services for CSHN
Department of Human Services
Division of Community & Family Health
11 State House Station
Augusta, ME 04333-0011
(207) 287-8188
(207) 287-5355 Fax

Director
Office of Child Care & Head Start
Maine Department of Human Services
221 State Street
Augusta, ME 04333-0011
(207) 287-5060
(207) 287-5281 Fax

**Passamaquoddy Tribe
Pleasant Point Reservation
P.O. Box 343
Perry, ME 04667
(207) 853-2600
(207) 853-6039 Fax

**Arrostook Band of Micmac Indians
Child Welfare Programs
P.O. Box 772
Presque Isle, ME 04769
(207) 764-3249
(207) 769-7408 Fax

**Program Director
Penobscot Indian Nation
5 River Road, Indian Island
Old Town, ME 04468
(207) 827-4789
(207) 827-5022 Fax

**Health Director
Passamaquoddy Tribe
Indian Township Health Center
P.O. Box 97
Princeton, ME 04668
(207) 796-2321
(207) 796-2422 Fax

**Houlton Band of Maliseet Indians
Department of Social Services
Route 3, Box 450
Houlton, ME 04730-9514
(207) 532-4273
(207) 532-2660 Fax

MARYLAND

Secretary
Department of Health & Mental Hygiene
Herbert R. O'Connor Bldg..
201 West Preston Street, Fifth Floor
Baltimore, MD 21201
(410) 767-6505
(410) 767-6489 Fax

EPSDT Coordinator
(410) 767-1485
(410) 333-5185 Fax

Director
Maternal Health & Family Planning
Maryland Department of Health & Mental Hygiene
201 West Preston Street, Room 318
Baltimore, MD 21201
(410) 767-6721
(410) 333-5233 Fax

Director
Office of Children's Health
Department of Health & Mental Hygiene
201 West Preston Street, Room 421A
Baltimore, MD 21201
(410) 767-6760
(410) 333-7956 Fax

Director
Child Care Administration
Maryland Department of Human Resources
311 W. Saratoga Street, 1st Floor
Baltimore, MD 21201
(410) 767-7128
(410) 333-8699 Fax

MASSACHUSETTS

Commissioner
Division of Medical Assistance
600 Washington Street, 5th Floor
Boston, MA 02111
(617) 210-5690
(617) 210-5697 Fax

EPSDT Coordinator
(617) 210-5404
(617) 210-5003 Fax

Assistant Commissioner
Bureau of Family & Community Health
Massachusetts Department of Pubic Health
250 Washington Street, 5th Floor
Boston, MA 02108-4619
(617) 624-6090
(617) 624-6062 Fax

Director
Division of CSHCN
Bureau of Family &Community Health
Massachusetts Department of Public Health
250 Washington Street, 4th Floor
Boston, MA 02108-4619
(617) 624-5959
(617) 624-5990 Fax

Commissioner
Office of Child Care Services
Executive Office of Health &
Human Services
One Ashburton Place, Room 1105
Boston, MA 02108
(617) 626-2012
(617) 626-2028 Fax

**Human Services Director
Wampanoag Tribe of Gay Head
20 Black Brook Road
Gay Head, MA 02535
(508) 645-9265
(508) 645-3790 Fax

MICHIGAN

Director
Medical Services Administration
Michigan Department of Community
Health, Capitol Commons Center
P.O. Box 30479
Lansing, MI 48909-7979
(517) 335-5001
(517) 335-5007 Fax

EPSDT Coordinator
(517) 335-5118
(517) 335-5136 Fax

Director
Michigan Department of Public Health
P. O. Box 30195
3423 North Martin Luther King, Jr., Blvd.
Lansing, MI 48909
(517) 335-9371
(517) 335-8560 Fax

Acting
Chief CSHCS Planning Division
Medical Services Administration
P.O. Box 30479
Lansing, MI 48909-7979
(517) 241-7193
(517) 335-5294 Fax

Manager
Child & Family Services Division
Child Care Division
Michigan Family Independence Agency
235 South Grand Ave.
P.O. Box 30037
Lansing, MI 48909
(517) 373-0356
(517) 241-7843 Fax

**Saginaw Chippewa Indian
Tribe of Michigan
7070 East Broadway
Mt. Pleasant, MI 48858
(517) 772-5700
(517) 772-3508 Fax

**Lac Vieux Desert Band of Lake Superior
Chippewa Indians
P.O. Box 249 - Choate Road
Watersmeet, MI 49969
(906) 358-4577
(906) 358-4785 Fax

**CCDBG Director
Sault St. Marie Tribe of Chippewa Indians
2218 Shunk Road
Sault St. Marie, MI 49783
(906) 632-5258 ext. 53746
(906) 632-5266 Fax

**Bay Mills Indian Community
Route 1, Box 313
Brimley, MI 49715
(906) 248-3241
(906) 248-3283 Fax

**Grand Traverse Band Chippewa
Benodjehn Child Care Center
2631 NW Bay Shore Drive
Suttons Bay, MI 49682
(218) 475-2952
Fax Number Unavailable

**Michigan Potawatomi of Hannahville
Housing Authority
N. 14911 Hannahville B-1 Road
Wilson, MI 49896
(906) 466-2952
(906) 466-2952 Fax

**Keweenaw Bay
795 Michigan Avenue
Baraga, MI 49908
(906) 353-7649
(906) 353-7919 Fax

MINNESOTA

Medicaid Director
Department of Human Services
444 Lafayette Road
Sixth Floor
St. Paul, MN 55155-3852
(612) 282-9921
(612) 297-3230 Fax

EPSDT Coordinator
(612) 296-6040
(612) 297-3230 Fax

Director
Division of Family Health
Minnesota Department of Health
717 Delaware Street SE
P. O. Box 9441
Minneapolis, MN 55440-9441
(612) 623-5167
(612) 623-5442 Fax

Section Manager
CSHCN
Minnesota Department of Health
717 Delaware Street SE
P.O. Box 9441
Minneapolis, MN 55440-9441
(612) 623-5140
(612) 623-5442 Fax

Child Care Fund
Minnesota Department of Children,
Families & Learning
Human Services Building
3rd Floor, Capital Square Bldg..
444 Lafayette Road
St. Paul, MN 55101
(612) 296-2030
(612) 296-5890 Fax

**Director, Early Childhood Programs
Bois Forte Reservation
P.O. Box 16
Nett Lake, MN 55772
(218) 757-3265
(218) 757-3312 Fax

**Mille Lacs Band of Chippewa Indians
HRC 67, Box 194
Onamia, MN 56359
(612) 532-4690
(612) 532-4718 Fax

**Child Care Coordinator
White Earth Reservation Tribal Council
Ojibwa Employment &Training
P.O. Box 37
Wanbun, MN 56589
(218) 473-2141
(218) 473-2186 Fax

**Child Care Coordinator
Leech Lake Tribal Council
RR 3, Box 100
Cass Lake, MN 56633
(218) 335-6831
(218) 335-8309 Fax

**Shakopee Mdewakanton Sioux Community
2330 Sioux Trail NW
Prior Lake, MN 55372
(612) 496-6801
(612) 496-6820 Fax

**Fond du Lac Band of the Minnesota Chippewa Tribe
927 Trettel Lane
Cloquet, MN 55720
(218) 879-1227
(218) 879-8378 Fax

**Director, CCDF
Red Lake Band of Chippewa Indians
P.O. Box 310
Red Lake, MN 56671
(218) 679-3306
(218) 679-3488 Fax

**Grand Portage Reservation
P.O. Box 428
Grand Portage, MN 55605
(218) 475-2564
(218) 475-2320 Fax

**ICW Director
Upper Sioux Indian Community
P.O. Box 147
Granite Falls, MN 56241
(612) 564-2360
(612) 564-3264 Fax

MISSISSIPPI

Executive Director
Division of Medicaid
Office of the Governor
Suite 801, Robert E. Lee Building
239 North Lamar Street
Jackson, MS 39201-1399
(601) 359-6050
(601) 359-6048 Fax

EPSDT Coordinator
(601) 359-6152
(601) 359-6147 Fax

Office Director
Office of Personal Health Services
Mississippi State Department of Health
2423 North State Street
P.O. Box 1700
Jackson, MS 39215-1700
(601) 960-7463
(601) 354-6104 Fax

Bureau Chief
Children & Adolescent Health
Mississippi State Department of Health
2423 North State Street
P. O. Box 1700
Jackson, MS 39215-1700
(601) 987-3965
(601) 354-6104 Fax

Director
Office for Children & Youth
Mississippi Department of Human Services
P.O. Box 352
Jackson, MS 39205-0352
(601) 359-4555
(601) 359-4422 Fax

**Early Education Planner
Mississippi Band of Choctaw Indians
Early Childhood Division
P.O. Box 6010
Philadelphia, MS 39350
(601) 656-5251
(601) 656-1992 Fax

MISSOURI

Director
Division of Medical Services
Department of Social Services
615 Howerton Court
P.O. Box 6500
Jefferson City, MO 65102-6500
(573) 751-6922
(573) 751-6564 Fax

EPSDT Coordinator
(573) 751-3277
(573) 526-2041 Fax

Director
Division of Maternal, Child & Family Health
Missouri Department of Health
930 Wildwood Drive
P. O. Box 570
Jefferson City, MO 65109
(573) 526-5520
(573) 526-5348 Fax

Chief
Bureau of Special Health Care Needs
Missouri Department of Health
930 Wildwood Drive
P. O. Box 570
Jefferson City, MO 65109
(573) 751-6246
(573) 751-6237 Fax

Unit Manager for Child Care Policy
Missouri Department of Social Services
Division of Family Services
P.O. Box 88, 615 Howerton Ct.
Jefferson City, MO 65103
(573) 751-4431
(573) 526-4837 Fax

**Director of Child Care
Eastern Shawnee Tribe of Oklahoma
P.O. Box 350
Seneca, MO 64865
(918) 666-2435
(918) 666-3325 Fax

MONTANA

Administrator
Division of Health Policy & Services
Department of Public Health &
Human Services
P.O. Box 202951
Cogswell Building
Helena, MT 59620
(406) 444-4540
(406) 444-1861 Fax

EPSDT Coordinator
(406) 444-3182
(406) 444-1861 Fax

Bureau Chief
Family & Community Health
Montana Department Public Health &
Human Services
Cogswell Bldg..
1400 Broadway, Room C-314
Helena, MT 59620
(406) 444-4740
(406) 444-2606 Fax

Program Manager
Special Health Services
Montana Department Public Health &
Human Services
Cogswell Bldg., Room C-314
P.O. Box 202951
1400 Broadway,
Helena, MT 59620
(406) 444-3622
(406) 444-2606 Fax

Child Care Program specialist
Department of Public Health &
Human Services
Cogswell Bldg., Room A-16
P.O. Box 8005
Helena, MT 59604-8005
(406) 444-0309 or (406) 444-1828
(406) 444-2547 Fax

**Coordinator
Fort Belknap Indian Community Council
Fort Belknap Agency
RR 1, Box 66
Harlem, MT 59526
(406) 353-2205
(406) 353-2797 Fax

**CCDBG Coordinator
Fort Peck Assiniboine/Sioux Tribes
P.O. Box 1027
Poplar, MT 59255
(406) 768-5131
(406) 768-5133 Fax

**Child Care Coordinator
Confederated Salish & Kootenai Tribes of
the Flathead Nation
P.O. Box 278
Pablo, MT 59855
(406) 675-2700
(406) 675-2806 Fax

**Director, Social Services
Crow Tribe of Montana
P.O. Box 159
Crow Agency, MT 59022
(406) 638-2601 ext. 106
(406) 638-7283 Fax

**Block Grant Manager
Blackfeet Nation
Head Start Program
P.O. Box 537
Browning, MT 59417
(406) 338-7370
(406) 338-7030 Fax

**Chippewa-Cree Tribe/Rocky Boys Reservation
Stone Child College Child Care Center
649 RB Route, Box 1082
Box Elder, MT 59521
(406) 395-4331
(406) 395-4836 Fax

**Case Manager
Northern Cheyenne Tribal Council
P.O. Box 368
Lame Deer, MT 59043
(406) 477-8341
(406) 477-6210 Fax

NEBRASKA

Administrator
HHF Finance & Support-Medicaid Division
Department of Social Services
301 Centennial Mall South
Fifth Floor
Lincoln, NE 68509-5026
(402) 471-9147
(402) 471-9092 Fax

EPSDT Coordinator
(402) 471-9366
(402) 471-9092 Fax

Administrator
Division of Family Health
Nebraska Department of Health & Human Services
301 Centennial Mall South, P.O. Box 95044
Lincoln, NE 68509-5044
(402) 471-3980
(402) 471-7049 Fax

Administrator
Handicapped Children's Program
Nebraska Department of Health & Human Services
301 Centennial Mall South, P.O. Box 95044
Lincoln, NE 68509-5044
(402) 471-9283
(402) 471-9455 Fax

Acting Administrator
Child Care & Development Program
Nebraska Department of Health and Human Services
P.O. Box 95044
Lincoln, NE 68509
(402) 471-9676
(402) 471-9455 Fax

**Grant Writer
Ponca Tribe of Nebraska
1701 E Street
Lincoln, NE 68508
(402) 428-9222
(402) 438-9226 Fax

**CCDBG Coordinator
Omaha Tribe of Nebraska
Mark of Honor Youth Lodge
P.O. Box 307
Macy, NE 68039
(402) 837-5391
(402) 837-5308 Fax

**CCDBG Coordinator
Winnebago Tribe of Nebraska
Tekawitha Child Care Center
P.O. Box 687
Winnebago, NE 68071
(402) 878-2447
(402) 878-2632 Fax

**Tribal Chairman
Santee Sioux Tribe of Nebraska
Route 2, Box 163
Niobrara, NE 68760
(402) 857-2302
(402) 857-2307 Fax

NEVADA

Deputy Administrator
Welfare Division
Department of Human Resources
2527 North Carson Street
Carson City, NV 89710
(702) 687-4867
(702) 687-5080 Fax

EPSDT Coordinator
(702) 687-4974
(704) 687-8724 Fax

Bureau Chief
Family Health Services
Nevada State Health Division
505 East King Street, Room 200
Carson City, NV 89701-4797
(702) 687-4885
(702) 687-1383 Fax

Administrative Services Officer
Family Health Services
Nevada State Health Division
505 East King Street, Room 201
Carson City, NV 89701-4797
(702) 687-4740
(702) 687-3859 Fax

Management Analyst IV
Nevada Department of Human Resources
505 E. King Street, Room. 600
Carson City, NV 89701
(702) 687-4474
(702) 687-4733 Fax

**CCDBG Coordinator
Fallon Paiute Shoshone Tribes
991 Rio Vista
Fallon, NV 89406
(702) 423-1155
(702) 423-8960 Fax

**CCDBG Administrator
Walker River Paiute Tribe/Social Services
Walker River Paiute Indian Reservation
P.O. Box 146
Schurz, NV 89427
(702) 773-7058
(702) 773-2058 Fax

**CCDBG Coordinator
Fort McDermitt Paiute-Shoshone Tribe
P.O. Box 457
McDermitt, NV 89421
(702) 532-8259
(702) 532-8319 Fax

**Inter-tribal Council of Nevada
P.O. Box 7440
Reno, NV 89510
(702) 355-0600
(702) 355-5211 Fax

**CCDBG Administrator
Pyramid Lake Paiute Tribe
Social Services Department
P.O. Box 256
Nixon, NV 89424
(702) 574-1047
(702) 574-1052 Fax

**Shoshone-Paiute Tribe of Duck Valley Reservation
P.O. Box 219
Owyhee, NV 89832
(702) 757-3211
(702) 757-2219 Fax

**CCDBG Administrator
Reno-Sparks Indian Colony
98 Colony road
Reno, NV 89502
(702) 329-2936
(702) 329-8710 Fax

**CCDBG Administrator
Ely Shoshone Tribe
16 Shoshone Circle
Ely, NV 89301
(702) 289-3013
(702) 289-3156 Fax

NEW HAMPSHIRE

Medicaid Administrator
Office Medical Services
Division of Human Services
Department of Health & Human Services
6 Hazen Drive
Concord, NH 03301-6521
(603) 271-4353
(603) 271-4376 Fax

EPSDT Coordinator
(603) 271-4823
(603) 271-4376 Fax

Chief
MCHB
New Hampshire Division of Public Health Services
Office of Family & Community Health
6 Hazen Drive
Concord, NH 03301
(603) 271-4516
(603) 271-3827 Fax

Chief
Bureau of Special Medical Services
New Hampshire Division of
Public Health Services
Office of Family & Community Health
6 Hazen Drive
Concord, NH 03301
(603) 271-4596
(603) 271-4902 Fax

Child Care Coordinator
Office of the Commissioner
Department of Health & Human Services
6 Hazen Drive
Concord, NH 03301
(603) 271-4343
(603) 271-7982 Fax

NEW JERSEY

Director
Division of Medical Assistance
& Health Services
Department of Human Services
P.O. Box 712, 7 Quakerbridge Plaza
Trenton, NJ 08625
(609) 588-2600
(609) 588-3583 Fax

EPSDT Coordinator
(609) 588-2718
(609) 588-3889 Fax

Director
MCH & Regional Services
New Jersey State Department of
Health & Senior Services
50 East State Street, CN 364
Trenton, NJ 08625-0364
(609) 292-5656
(609) 292-3580 Fax

Acting Director
Special Child Health Services
New Jersey State Department of
Health & Senior Services
50 East State Street, P.O. Box 364
Trenton, NJ 08625-0364
(609) 292-5676
(609) 292-3580 Fax

Acting Deputy Director
Division of Family Development
Department of Human services
P.O. Box 716
Trenton, New Jersey 08625
(609) 588-2415
(609) 588-3369 Fax

NEW MEXICO

Director
Medical Assistance Division
New Mexico Humans
Services Department
P.O. Box 2348
Santa Fe, NM 87504-2348
(505) 827-3106
(505) 827-3185 Fax

EPSDT Coordinator
(505) 827-3134
(505) 827-3185 Fax

Bureau Chief
Department of Health, PHD, FHB
1190 St. Francis Drive, P.O. Box 26110
Santa Fe, NM 87502
(505) 827-2350
(505) 827-1697 Fax

Manager
Children's Medical Services
Department of Health, PHD
1190 St Francis Drive, P.O. Box 26110
Santa Fe, NM 87502
(505) 827-2350
(505) 827-1697 Fax

Acting Child Care Bureau Chief
NM Department of Children,
Youth & Families
1120 Paseo De Peralta
P.O. Drawer 5160
Santa Fe, NM 87502
(505) 827-7499
(505) 827-9978 Fax

**Pueblo of Santo Domingo
Kewa Day Care Program
P.O. Box 99
Santo Domingo Pueblo, NM 87052
(505) 465-2214
(505) 465-2688 Fax

**Pueblo of Jemez
P.O. Box 100
Jemez Pueblo, NM 87024
(505) 834-7366
(505) 834-9173 Fax

**Pueblo of Zia
135 Capito Square Drive
Zia Pueblo, NM 87053
(505) 867-3304
(505) 867-3308 Fax

**Pueblo of Santa Ana
2 Dove Road
Bernalillo, NM 87004
(505) 867-3301
(505) 867-3395 Fax

**Mescalero Apache Tribe
P.O. Box 176
Mescalero, NM 88340
(505) 671-4494
(505) 671-9191 Fax

**Pueblo of Taos
P.O. Box 1846
Taos, NM 87571
(505) 758-4108
(505) 758-3346 Fax

**Pueblo of Isleta
Department of Social Services
P.O. Box 1270
Isleta, NM 87022
(505) 869-2772
(505) 869-5923 Fax

**Child Care Coordinator
Pueblo of Acoma
P.O. Box 428
Acoma, NM 87034
(505) 552-6959
(505) 552-9455 Fax

**Pueblo of Cochiti
P.O. Box 70
Cochiti, NM 87072
(505) 465-2244
(505) 465-1135 Fax

**Pueblo of Sandia
P.O. Box 6008
Bernalillo, NM 87004
(505) 867-3317
(505) 867-3383 Fax

**Eight Northern Indian Pueblos Council
P.O. Box 969
San Juan Pueblo, NM 87566
(505) 852-4265
(505) 852-4835 Fax

**Pueblo of San Felipe
P.O. Box 4339
San Felipe, NM 87001
(505) 867-2311
(505) 867-2719 Fax

**Child Care Coordinator
Pueblo of Zuni
Child Care Development Program
P.O. Box 339
Zuni, NM 87327
(505) 782-4481
(505) 782-2700 Fax

**Pueblo of Laguna
Division of Early Childhood
P.O. Box 798
Laguna, NM 87026-0798
(505) 552-6467
(505) 552-6398 Fax

NEW YORK

Deputy Commissioner
Office of Medicaid Management
New York State Department of
Social Services
Empire State Plaza, Corning Tower
Room 1466
Albany, NY 12237-0722
(518) 486-4803
(518) 486-6852 Fax

EPSDT Coordinator
(518) 473-9855
(518) 473-5889 Fax

Director
Division of Family & Local Health
New York State Department of Health
Corning Tower Bldg..., Room 890
Albany, NY 12237-0618
(518) 473-7922
(518) 473-2015 Fax

Director
Bureau of Child & Adolescent Health
New York State Department of Health
Corning Tower Bldg..., Room 208
Albany, NY 12237-0618
(518) 474-2084
(518) 473-8673 Fax

Director
Bureau of Early Childhood Services
New York State Department of
Social Services
40 North Pearl Street, 11B
Albany, NY 12243
(518) 474-9454
(518) 474-9617 Fax

**Seneca Nation of Indians
P.O. Box 231
Salamanca, NY 14779
(716) 945-1790
(716) 945-3917 Fax

**Oneida India Nation
Family Services
RD 2, West Road
223 Genesse Street
Oneida, NY 13421
(315) 363-1002
(315) 363-0160 Fax

**St. Regis Mohawk Tribe
Community Building
RR #1, Box 8A
Hogansburg, NY 13655-9702
(518) 358-4516
(518) 358-3203 Fax

NORTH CAROLINA

Director
Division of Medical Assistance
Department of Human Resources
1985 Umstead Drive
P.O. Box 29529
Raleigh, NC 27626-0529
(919) 857-4011
(919) 733-6608 Fax

EPSDT Coordinator
(919) 857-4020 ext. 4045
(919) 733-2796 Fax

Director
Division of Women's & Children's Health
Department of Health & Human Services
P. O. Box 29597
Raleigh, NC 27626-0597
(919) 733-3816
(919) 715-3807 Fax

Chief
Children & Youth Section
Department of Health & Human Services
P. O. Box 29597
Raleigh, NC 27626-0597
(919) 715-3808
(919) 715-3187 Fax

Policy Consultant
Division of Child Development
Department of Human Resources
P.O. Box 29553
Raleigh, NC 27626-0553
(919) 662-4535
(919) 662-4569 Fax

**Executive Director
Eastern Band of Cherokee
Cherokee Center for Family Services
P.O. Box 507
Cherokee, NC 28719
(704) 497-5001
(704) 497-5818 Fax

NORTH DAKOTA

Director
Medicaid Department of Human Services
600 East Boulevard Avenue
Bismarck, ND 58505-0250
(701) 328-2321
(701) 328-1544 Fax

EPSDT Coordinator
(701) 328-2323
(701) 328-1544 Fax

Director
MCH
North Dakota State Department of Health
600 East Boulevard Avenue
Bismarck, ND 58505-0200
(701) 328-4532
(701) 328-1412 Fax

Director
Children's Special Health Services
North Dakota Department of
Human Services
600 East Boulevard Avenue
Bismarck, ND 58505-0269
(701) 328-2436
(701) 328-2359 Fax

Child Care Assistance
Program Administrator
North Dakota Department of
Human Services
600 East Boulevard Avenue
Bismarck, ND 58505-0250
(701) 328-4603
(701) 328-2359 Fax

**Child Care Coordinator
Three Affiliated Tribes
Fort Berthold Reservation
Employment Training Department
P.O. Box 597
New Town, ND 58763
(701) 627-4756
(701) 627-4496 Fax

**Child Care Specialist
Standing Rock Sioux Tribe
Agency Avenue
P.O. Box D
Fort Yates, ND 58538
(701) 854-3646
(701) 854-7281 Fax

**Child Care Administrator
Spirit Lake Sioux Tribe, Blue Building
P.O. Box 359
Fort Totten, ND 58335
(701) 766-1202
(701) 766-1236 Fax

**Jobs/Child Care Administrator
Turtle Mountain Band of Chippewa
P.O. Box 900
Belcourt, ND 58313
(701) 477-3602
(701) 477-8259 Fax

**Child Care Specialist
Trenton Indian Service Area
Child Care Assistance Program
P.O. Box 210
Trenton, ND 58853
(701) 572-8316
(701) 572-0124 Fax

NORTHERN MARIANA ISLAND

Medicaid Administrator
Department of Public Health
& Environmental Services
Commonwealth of the Northern
Mariana Islands
P.O. Box 409 CK
Saipan, MP 96950
(011) (670) 234-8950 ext. 2905
(011) (670) 234-8931 Fax

EPSDT Coordinator
(011) 670 234-8950 ext. 2905

Director
Public Health Commonwealth
Health Center.
Department of Health-Environmental
Services
P. O. Box 409 CK
Saipan, MP 96950
(011) (670) 234-8950
(011) (670) 234-8930 Fax

Commissioner of Education
State Board of Education
CNMI
P.O. Box 1370 CK
Saipan, MP 98950
(011) (670) 322-6405
(011) (670) 322-4056 Fax

OHIO

Deputy Director
Office of Medicaid
Department of Human Services
30 East Broad Street
31st Floor
Columbus, OH 43266-0423
(614) 466-4443
(614) 752-3986 Fax

EPSDT Coordinator
(614) 466-6420
(614) 466-2908 Fax

Chief
Division of Family &
Community Health Services
Ohio Department of Public Health
246 North High Street, P.O. Box 118
Columbus, OH 43266-0118
(614) 466-3263
(614) 728-3616 Fax

Chief
Bureau for Children with
Medical Handicaps
Ohio Department of Public Health
P. O. Box 1603
Columbus, OH 43216-1603
(614) 466-1549
(614) 728-3616 Fax

Chief
Bureau of Child Care
Ohio Department of Human Services
65 E. State Street, 5th Floor
Columbus, OH 43215
(614) 466-1043
(614) 728-6803 Fax

OKLAHOMA

State Medicaid Director
Oklahoma Health Care Authority
4545 North Lincoln Boulevard
Suite 124
Oklahoma City, OK 73105
(405) 530-3439
(405) 530-3471 Fax

EPSDT Coordinator
(405) 530-3452
(405) 530-3470 Fax

Chief
Child Health & Guidance Service
Oklahoma State Department of Health
MCH Service, 1000 NE Tenth Street
Oklahoma City, OK 73117-1299
(405) 271-4477
(405) 271-1011 Fax

Division Administrator
Family Support Services
Department of Human Services
P.O. Box 25352
Oklahoma City, OK 73125
(405) 521-3076
(405) 521-4158 Fax

Program Administrator
Office of Child Care
Department of Human Services
4545 N Lincoln, Suite 100
Oklahoma City, OK 73105
(405) 521-3561
(405) 521-0391 Fax

**Otoe-Missouria Tribe of Oklahoma
Route 1, Box 62
Red Rock, OK 74651
(405) 723-4464
(405) 723-4273 Fax

**CCDBG Coordinator
Cheyenne & Arapaho Tribes of Oklahoma
P.O. Box 38
Concho, OK 73022
(405) 262-0345 ext. 145
(405) 262-0745 Fax

**Wyandotte Tribe of Oklahoma
P.O. Box 250
Wyandotte, OK 74370
(918) 678-2297
(918) 678-2944 Fax

**Tribal Administrator
Delaware Tribe of Indians
108 South Seneca
Bartlesville, OK 74003
(918) 336-5272
(918) 336-5513 Fax

**Social Services Director
Wichita & Affiliated Tribes
P.O. Box 729
Anadarko, OK 73005
(405) 247-2425
(405) 247-2430 Fax

**Chickasaw Nation
Arlington at Mississippi
P.O. Box 1548
Ada, OK 74820
(405) 436-5599
(405) 436-7275 Fax

**Child Care & Development Services
Cherokee Nation of Oklahoma
P.O. Box 948
Tahlequah, OK 74465
(918) 458-4404
(918) 458-6165 Fax

**Apache Tribe of Oklahoma
P.O. Box 1220
Anadarko, OK 73005
(405) 247-9493
(405) 247-9872 Fax

**Absentee Shawnee Tribe of Oklahoma
2025 South Gordon Cooper
Shawnee, OK 74801
(405) 275-4030
(405) 878-4536 Fax

**Social Services Director
Kiowa Tribe of Oklahoma
P.O. Box 369
Carnegie, OK 73015
(405) 654-2300 ext. 233
(405) 654-2406 Fax

**Choctaw Nation of Oklahoma
Drawer 1210
16th and Locust
Durant, OK 74701-1219
(405) 920-1801
(405) 924-6644 Fax

**Iowa Tribe of Oklahoma
RR 1, Box 721
Perkins, OK 74059
(405) 547-2402
(405) 547-5294 Fax

**Modoc Tribe of Oklahoma
515 G Southeast
Miami, OK 74354
(918) 542-1190
(918) 542-5415 Fax

**Citizen Band Potawatomi Indian
Tribe of Oklahoma
1901 S. Gordon Cooper Drive
Shawnee, OK 74801
(405) 275-3121
(405) 275-6653 Fax

**Kialegee ETVLWV
P.O. Box 332
Wetumka, OK 74883
(405) 452-3262
(405) 452-3413 Fax

**Seminole Nation of Oklahoma
Indian Child Welfare Office
P.O. Box 1498
Wewoka, OK 74884-1498
(405) 257-6105
(405) 257-6205 Fax

**Kaw Nation of Oklahoma
Drawer 50
Kaw City, OK 74641
(405) 269-2552
(405) 269-2301 Fax

**Comanche Tribe of Oklahoma
P.O. Box 908
Lawton, OK 73502
(405) 492-3792
(405) 492-3742 Fax

**Alabama-Quassarte Tribal Town
P.O. Box 537
Henryetta, OK 74437
(918) 652-8708
(918) 652-8708 Fax

**Caddo Indian Tribe of Oklahoma
P.O. Box 487
Binger, OK 73009
(405) 656-2812
(405) 656-2892 Fax

**Central Tribes of the Shawnee Area
526 North Kimberly
Shawnee, OK 74801
(405) 275-4870
(405) 275-9684 Fax

**Pawnee Tribel of Oklahoma
P.O. Box 470
Pawnee, OK 74058
(918) 762-3621
(918) 762-6446 Fax

**Child Care Director
Tonkawa Tribal Business Community
P.O. Box 70
Tonkawa, OK 74653
(405) 628-4926
(405) 628-3375 Fax

**Kickapoo Tribe of Oklahoma
P.O. Box 70
McLoud, OK 74851
(405) 964-2075
(405) 964-2745 Fax

**Thlopthlocco Tribal Town
P.O. Box 706
Okemah, OK 74859
(918) 623-2620
(918) 623-0419 Fax

**Delaware Tribe of Western Oklahoma
P.O. Box 825
Anadarko, OK 73005
(405) 247-2448
(405) 247-9393 Fax

**Child Care Director
Miami Tribe of Oklahoma
P.O. Box 1326
Miami, OK 74355
(918) 542-1445
(918) 542-7260 Fax

**Coordinator, Child Care
Assistance Program
Ponca Tribe of Oklahoma
20 White Eagle Drive
Ponca City, OK 74601
(405) 762-8104
(405) 763-0126 Fax

**Osage Nation, Federal Programs
627 Grandview
Pawhuska, OK 74056
(918) 287-2510
(918) 287-3416 Fax

**Tribal Administrator
Quapaw Tribe of Oklahoma
P.O. Box 765
Quapaw, OK 74363
(918) 542-1853
(918) 542-4694 Fax

**Muscogee (Creek) Nation
Office of Child Care
P.O. Box 580
Okmulgee, OK 74447
(918) 758-1463
(918) 758-1498 Fax

OREGON

Director
Office of Medical Assistance Programs
Department of Human Resources
500 Summer Street, NE
Human Resources Building, Third Floor
Salem, OR 97310-1014
(503) 945-5767
(503) 373-7689 Fax

EPSDT Coordinator
(503) 945-6490
(503) 373-7689 Fax

Assistant Administrator
Oregon State Health Division
800 NE Oregon Street, Suite 850
Portland, OR 97232
(503) 731-4398
(503) 731-4083 Fax

Child & Adolescent Health Manager
Oregon State Health Division
800 NE Oregon Street, Suite 825
Portland, OR 97232
(503) 731-8365
(503) 731-4083 Fax

Administrator
Oregon Department of Employment
Child Care Division
875 Union Street, NE
Salem, OR 97311
(503) 947-1515
(503) 947-1531 Fax

**Siletz Tribe
P.O. Box 649
Siletz, OR 97380
(503) 444-2532
(503) 444-2307 Fax

**Klamath Tribe
P.O. Box 436
Chiloquin, OR 97624
(541) 783-2219
(541) 783-2029 Fax

**Cow Creek Tribe
2400 Stewart Parkway, Suite 300
Roseburg, OR 97470
(541) 672-9405
(541) 673-0432 Fax

**Tribal Chair
Burns Paiute Tribe
HC-71
100 Pa'si'go' Street
Burns, OR 97720
(503) 573-1511
(503) 573-2323 Fax

** Confederated Tribes of Umatilla
Indian Reservation
P.O. Box 638
Pendleton, OR 97801
(541) 276-7011 ext. 327
(541) 278-5391 Fax

**Coquille Tribe
600 Miluk Drive
P.O. Box 3190
Coos Bay, OR 97420
(503) 888-9494
(503) 888-3431 Fax

**Confederated Tribes of the Warm
Springs Reservation
P.O. Box C
1257 Kot-num Road
Warm Springs, OR 97761
(503) 553-3241
(503) 553-3379 Fax

**Grande Ronde Confederated Tribes
9615 Grande Ronde Road
Grand Ronde, OR 97347
(800) 422-0232
(541) 673-0432 Fax

**Confederated Tribes of Coos Bay
Lower Umpqua & Siuslaw Indians
338 Wallace Avenue
P.O. Box 3298
Coos Bay, OR 97420
(503) 888-9577
(503) 888-5388 Fax

PENNSYLVANIA

Deputy Secretary for
Medical Assistance Programs
Department of Public Welfare
P.O. Box 2675, Room 515
Health & Welfare Building
Harrisburg, PA 17105-2675
(717) 787-1870
(717) 787-4639 Fax

EPSDT Coordinator
(717) 772-6341
(717) 772-6366 Fax

Director
Bureau of MCH Preventive Health
Pennsylvania Department of Health
H&W Bldg., Room 733
P.O. Box 90
Harrisburg, PA 17108
(717) 787-7192
(717) 772-0323 Fax

Director
Division of Special Health Care Needs
Pennsylvania Department of Health
H&W Bldg..., Room 726
P.O. Box 90
Harrisburg, PA 17108
(717) 783-5436
(717) 772-0323 Fax

Director
Bureau of Child Day Care Services
Department of Public Welfare
P.O. Box 2675
Harrisburg, PA 17105-2675
(717) 787-8691
(717) 787-1529 Fax

PUERTO RICO

Medicaid Director
Office of Economic Assistance
to the Medically Indigent
Department of Health
G.P.O. Box 70184
San Juan, PR 09936
(787) 250-7429
(787) 250-0990 Fax

EPSDT Coordinator
(787) 765-1230
(787) 250-0990 Fax

MCH Director
Puerto Rico Department of Health
Call Box 70184
San Juan, PR 00936-8184
(787) 274-5680
(787) 274-7824 Fax

CSHCN Director
Puerto Rico Department of Health
Call Box 70184
San Juan, PR 00936-8184
(787) 274-7701
(787) 250-6547 Fax

Office of Child Services &
Community Development
Ponce de Leon Avenue, #2 San Juan
Box 15091
San Juan, PR 00901
(787) 723-1113
(787) 721-2245 Fax

RHODE ISLAND

Acting Associate Director
for Medical Services
Department of Human Services
600 New London Avenue
Cranston, RI 02920
(401) 464-3575
(401) 464-3496 Fax

EPSDT Coordinator
(401) 464-2176
(401) 464-2185 Fax

Medical Director
Division of Family Health
Rhode Island Department of Health
Three Capitol Hill, Room 302
Providence, RI 02908-5097
(401) 222-2312
(401) 222-1442 Fax

Assistant. Medical Director
Division of Family Health
Rhode Island Department of Health
Three Capitol Hill, Room 302
Providence, RI 02908-5097
(401) 222-2312
(401) 222-1442 Fax

Administrator
Office of Child Care
Individual Family Support Services
Louis Pasteur Building 57
Howard Avenue
Cranston, RI 02920
(401) 464-3415
(401) 464-1881 Fax

**Director of Education
Narragansett Indian Tribe
P.O. Box 268
Charlestown, RI 02813
(401) 789-7821
(401) 782-1798 Fax

SOUTH CAROLINA

Interim Director
Department of Health & Human Services
P.O. Box 8206
Columbia, SC 29202-8206
(803) 253-6100
(803) 253-4137 Fax

EPSDT Coordinator
(803) 253-6121
(803) 253-7512 Fax

Director
Division of State & National Initiative
Mills/Jarett Complex, Box 101106
Columbia, SC 29211
(803) 737-4191
(803) 734-4442 Fax

Director
Children's Rehabilitative Services
DHEC
Mills/Jarett Complex, Box 101106
Columbia, SC 29211
(803) 737-4072
(803) 737-4078 Fax

Division Director
Community Services Department
Department of Human Services
P.O. Box 8206
Columbia, SC 29202-8206
(803) 253-6154
(803) 253-6152 Fax

*Catawba Indian Nation
536 Old Friendship Road
Rock Hill, SC 29730
(803) 329-0726
(803) 329-9859 Fax

SOUTH DAKOTA

Program Administrator
Medical Services
Department of Social Services
Richard F. Kneip Building
700 Governors Drive
Pierre, SD 57501-2291
(605) 773-3495
(605) 773-5246 Fax

EPSDT Coordinator
(605) 773-3495
(605) 773-5246 Fax

Administrator
Office of Family Health
South Dakota Department of Health
615 East 4th Street
Pierre, SD 57501
(605) 773-3737
(605) 773-5509 Fax

Manager
Children's Special Health Services
SD Department of Health
615 East 4th Street
Pierre, SD 57501-3185
(605) 773-3737
(605) 773-5509 Fax

Program Administrator
Child Care Services
South Dakota Department of Social Services
700 Governors Drive
Pierre, SD 57501-2291
(605) 773-4766
(800) 227-3020 (within South Dakota only)
(605) 773-6834 Fax

**Child Care Director
Lower Brule Sioux Tribe
Kul Wicasa Oyate
P.O. Box 187
Lower Brule, SD 57548
(605) 473-5244
(605) 473-0717 Fax

**Sisseton-Wahpeton Sioux Tribe
Lake Traverse Reservation
Veterans Memorial Drive
P.O. Box 509
Agency Village, SD 57262
(605) 698-3911 ext. 450
(605) 698-3708 Fax

**Child Care Coordinator
Yankton Sioux Tribe
C/O Coast to Coast
211 S. Main
Wagner, SD 57380
(605) 384-3641
(605) 384-5687 Fax

**Director
Cheyenne River Sioux Tribe
Unki Takoja Oti Child Care Center
P.O. Box 590
Eagle Butte, SD 57625
(605) 964-7151
(605) 964-4151 Fax

**Child Care Coordinator
Crow Creek Sioux Tribe/Healthy Start
P.O. Box 439
Fort Thompson, SD 57339
(605) 245-2221
(605) 245-2389 Fax

**Indian Child Welfare Planner
Flandreau Santee Sioux Tribe
701 W. Broad Avenue
P.O. Box 283
Flandreau, SD 57028
(605) 997-3844
(605) 997-3694 Fax

**Director
Oglala Sioux Tribe
OUT Health & Human Services
P.O. Box H
Pine Ridge, SD 57770-0379
(605) 867-5172
(605) 867-5666 Fax

**Child Care Coordinator
Rosebud Sioux Tribe
Child & Family Services
P.O. Box 430
Rosebud, SD 57570
(605) 747-5264
(605) 747-2243 Fax

TENNESSEE

Director of TennCare
Department of Finance Administration
729 Church Street
Nashville, TN 37247-6501
(615) 741-0213
(615) 741-0882 Fax

EPSDT Coordinator
(615) 741-0368
(615) 741-1338 Fax

Director
Tennessee Department of Health, MCH
425 5th Ave., N, 5th Floor
Cordell HullBldg.g..
Nashville, TN 37247-4701
(615) 741-7353
(615) 741-1063 Fax

Director
Tennessee Department of Health, CSS
425 5th Ave., N, 5th Floor
Cordell Hull Bldg...
Nashville, TN 37247-4701
(615) 741-8530
(615) 741-1063 Fax

Director
Day Care Services
Tennessee Department of Human Services
Citizens Plaza - 14th Floor
400 Deaderick Street
Nashville, TN 37248-9600
(615) 313-4778
(615) 532-9956 Fax

TEXAS

Commissioner
Health & Human Services Commission
P.O. Box 13247
Austin, TX 78711-3247
(512) 424-6517
(512) 424-6585 Fax

EPSDT Coordinator
(512) 458-7745
(512) 458-7256 Fax

Chief
Bureau of Children's Health
Texas Department of Health
1100 W 49th Street
Austin, TX 78756
(512) 458-7700
(512) 458-7203 Fax

Director
CSHCN Planning & Policy Development
Texas Department of Health
Bureau of Children's Health
1100 W 49th Street
Austin, TX 78756
(512) 458-7355
(512) 458-7238 Fax

Director of Child Care/Work & Family
Clearinghouse
101 E. 15th Street, Room 416T
Austin, TX 78778
(512) 936-3227
(512) 936-3223 Fax

**Tribal Planner/Grantwriter
Ysleta Del Sur Pueblo
119 S. Old Pueblo Road
P.O. Box 17579 Ysleta Station
El Paso, TX 79917
(915) 859-7913
(915) 859-2988 Fax

**Day Care Center Director
Alabama-Coushatta Tribe of Texas
Route 3, Box 640
Livingston, TX 77351
(409) 563-2600
(409) 563-4397 Fax

UTAH

Director
Division of Health Care Financing
Department of Health
288 North 1460 West, Third Floor
Salt Lake City, UT 84116-0580
(801) 538-6406
(801) 538-6099 Fax

EPSDT Coordinator
(801) 538-6303
(801) 538-6099 Fax

Bureau Director
Community & Family Health Services
Utah Department of Health
P.O. Box 142001
Salt Lake City, UT 84114-2001
(801) 538-6869
(801) 538-9409 Fax

Division Director
Community & Family Health Services
Utah Department of Health
P.O. Box 142001
Salt Lake City, UT 84114-2001
(801) 538-6901
(801) 538-6510 Fax

Assistant Director
Department of Work Force Services
P.O. Box 45249
140 E. 300 South
Salt Lake City, Utah 84145-0249
(801) 536-7400
(801) 536-7420 Fax

**Social Services Coordinator
Paiute Indian Tribe of Utah
600 N. 100 E Paiute Drive
Cedar City, UT 84720
(801) 586-5914
(801) 586-7388 Fax

**Child Care Coordinator
Ute Indian Tribe
P.O. Box 190
Fort Duchesne, UT 84026
(801) 722-5141 ext. 154
(801) 722-2374 Fax

VERMONT

Director
Office of Health Access
Department of Social Welfare
103 South Main Street
Waterbury, VT 05671-1201
(802) 241-2880
(802) 241-2897 Fax

EPSDT Coordinator
(802) 241-3984:
(802) 241-2897 Fax

MCH Director
Health Improvement
Vermont Department of Health
108 Cherry Street, P.O. Box 70
Burlington, VT 05402
(802) 863-7270
(802) 651-1634 Fax

Director
CSHN
Vermont Department of Health
108 Cherry Street, P.O. Box 70
Burlington, VT 05402
(802) 863-7338
(802) 863-7635 Fax

Director
Child Care Services Division
Vermont Department of Social
& Rehabilitative Services
Osgood Building, 2nd Floor
103 South Main Street
Waterbury, VT 05671-2401
(802) 241-3110
(802) 241-1220 Fax

VIRGINIA

Deputy Director
Department of Medical Assistance Services
600 East Broad Street
1st Floor Lobby
Richmond, VA 23219
(804) 786-7933
(804) 371-4981 Fax

EPSDT Coordinator:
(804) 371-0861
(804) 786-5799 Fax

Policy Analyst
Office of Family Health Services
1500 East Main Street, Suite 104
Richmond, VA 23219
(804) 371-4125
(804) 692-0184 Fax

Director
CSHCN Program
Division of child & Adolescent Health
1500 East Main Street, Suite 138
Richmond, VA 23219
(804) 786-3693
(804) 225-3307 Fax

Commissioner
Virginia Department of Social Services
730 East Broad Street
Richmond, VA 23219
(804) 692-1900
(804) 692-1949 Fax

VIRGIN ISLANDS

Director
Bureau of Health Insurance &
Medical Assistance
Department of Health
210-3A Altona
Suite 302 Frostco Center
Charlotte Amalie, VI 00802
(340) 774-4624
(340) 774-4918 Fax

EPSDT Coordinator
(340) 774-4624
(340) 774-4918 Fax

Director
MCH & CSHCN
VI Department of Health
3500 Estate Richmond
C. Harwood Complex
C'Sted, St. Croix, VI 00820-4320
(340) 773-1311
(340) 773-5884 Fax

Clinical Care Coordinator
VI Department of Health
ElaineCo Complex, 2nd Floor
St. Thomas, VI 00802
(340) 777-8804
(340) 776-4501 Fax

Project Administrator
Virgin Islands Department of
Human Services
Knud Kansen Complex, Bldg. A
1303 Hospital Grounds
Charlotte Amalie, VI 00802
(809) 774-0930 ext. 4181
(809) 774-3466 Fax

WASHINGTON

Assistant Secretary
Medical Assistance Administration
Department of Social & Health Services
P.O. Box 45080
Olympia, WA 98504-5080
(360) 753-1777
(360) 664-0788 Fax

EPSDT Coordinator
(360) 586-2754
(360) 753-7315

Assistant Secretary, Community &
Family Health
Washington State Department of Health
P.O. Box 47830, New Market Industrial
Campus Bldg.8
Olympia, WA 98504-7830
(360) 236-3721
(360) 664-4500 Fax

Office Director
Maternal & Child Health
Washington State Department of Health
P.O. Box 47880, Airdustrial Park Bldg. 7
Olympia, WA 98504-7880
(360) 236-3581
(360) 586-7868 Fax

Chief
Office of Child Care Policy
Department of Social & Health Services
P.O. Box 5700
Olympia, WA 98504-5700
(360) 902-8038
(360) 902-7903 Fax

**Nooksack Tribal Council
P.O. Box 157
Deming, WA 98244-1824
(360) 592-5176 ext. 3241
(360) 592-5721 Fax

**Quileute Tribal Council
P.O. Box 279
La Push, WA 98350-0279
(360) 374-6163 ext. 2115
(360) 374-9608 Fax

**South Puget Intertribal Planning Council
SE 2750 Old Olympic Highway
Shelton, WA 98584
(360) 426-3990
(360) 427-8003 Fax

**Makah Tribal Council
P.O. Box 115
Neah Bay, WA 98357
(360) 645-3287
(360) 645-2876 Fax

**Spokane Tribal Business Council
P.O. Box 100
Wellpinit, WA 99040
(509) 258-7502
(509) 258-7029 Fax

**Muckleshoot Indian Tribal Council
39015 172nd Avenue, SE
Auburn, WA 98002
(206) 939-6648 ext. 143
(206) 939-5311 Fax

**Child Care Coordinator
Yakama Indian Nation
P.O. Box 151
Fort Road
Toppenish, WA 98948
(509) 865-5121
(509) 865-6060 Fax

**Chairperson
Samish Tribal Nation
P.O. Box 217
Anacortes, WA 98221
(360) 293-6404
(360) 299-0790 Fax

**Tulalip Tribes
6700 Totem Beach Road
Marysville, WA 98270
(360) 651-4380
(360) 651-4032 Fax

**Early Childhood Programs Director
Port Gamble S'klallam Tribe
31912 Little Boston Road, NE
Kingston, WA 98346
(360) 297-6258
(360) 297-7097 Fax

**Sauk-Suiattle Indian Tribe
5318 Chief Brown Lane
Darrington, WA 98241
(360) 436-1854
(360) 436-1511 Fax

**Suquamish Tribe
P.O. Box 498
Suquamish, WA 98392
(360) 297-3203
(360) 598-6116 Fax

**Puyallup Tribe of Indians
2002 E. 28th Street
Tacoma, WA 98404
(206) 593-0242
(206) 572-5913 Fax

**Jamestown S'klallam Tribe
1033 Old Blyn Highway
Sequim, WA 98382
(360) 681-4628
(360) 681-3402 Fax

**Quinault Indian Nation
P.O. Box 189
Taholah, WA 98587
(360) 276-8211 ext. 463
(360) 276-4191 Fax

**Upper Skagit Tribe
2284 Community Plaza Way
Sedro Woolley, WA 98284
(360) 856-4200 ext. 264
(360) 856-3537 Fax

**Lummi Indian Business Council
2616 Lwoma Road
Bellingham, WA 98226-9298
(360) 758-2781
(360) 384-5521 Fax

**Colville Confederated Tribes
P.O. Box 150
Nespelem, WA 99155
(509) 634-4711 ext. 582
(509) 634-8799 Fax

**Skokomish Indian Tribe
N. 80 Tribal Center Road
Shelton, WA 98584
(360) 426-7788
(360) 877-5943 Fax

**Lower Elwha Tribal Council
1666 Lower Elwha Road
Port Angeles, WA 98362
(360) 452-8471 ext. 103
(360) 452-3428 Fax

**CCDBG Coordinator
Stillaquamish Tribe of Indians
P.O. Box 277
3439 Stoluckquamish Lane
Arlington, WA 98223-0277
(360) 652-7362 ext. 223
(360) 435-7689 Fax

**Swinomish Indian Tribal Community
P.O. Box 388
Laconner, WA 98257
(360) 466-7276
(360) 466-1316 Fax

**Grant Coordinator
Kalispel Tribe of Indians
P.O. Box 39
Usk, WA 99180
(509) 445-1074
(509) 447-3025 Fax

WEST VIRGINIA

Commissioner
Bureau for Medical Services
Department of Health & Human Resources
Building 6, State Capitol Complex
Charleston, WV 25305
(304) 926-1700
(304) 926-1776 Fax

EPSDT Coordinator
(304) 926-1700
(304) 926-1776 Fax

Director
Office of Maternal & Child Health
1411 Virginia Street, East
Charleston, WV 25301-3013
(304) 558-5388
(304) 558-2183 Fax

Director
Division of Children's Specialty Care
Office of Maternal & Child Health
1116 Quarrier Street
Charleston, WV 25301
(304) 558-3071
(304) 558-2866 Fax

Director
Licensing & Day Care
Department of Health & Human Resources/Office of Social Services
Capitol Complex, Bldg.. 6
Charleston, WV 25305
(304) 558-7980
(304) 558-8800 Fax

WISCONSIN

Director
Bureau of Health Care Financing
Wisconsin Division of Health
One West Wilson Street, Room 250
P.O. Box 309
Madison, WI 53701-0309
(608) 266-2522
(608) 266-1096 Fax

EPSDT Coordinator
(608) 261-6739
(608) 266-1096 Fax

Section Chief
Wisconsin Division of Health
1414 E. Washington Avenue, Room 167
Madison, WI 53703-3044
(608) 266-2684
(608) 267-3824 Fax

Family Health Unit Supervisor
Wisconsin Division of Health
1414 E. Washington Avenue, Room 167
Madison, WI 53703-3044
(608) 267-3561
(608) 267-3824 Fax

Division of Children & Family
Services
Department of Health & Family Services
1 West Wilson Street
P.O. Box 8916
Madison, WI 53708-8916
(608) 267-3905
(608) 264-9832 Fax

**Red Cliff Band of
Lake Superior Chippewas
P.O. Box 529
Bayfield, WI 54814
(715) 779-3734
(715) 779-3704 Fax

**Lac du Flambeau Band of Lake Superior
Chippewa Indians
P.O. Box 67
Lac du Flambeau, WI 54538
(715) 588-3303
(715) 588-7930 Fax

**Stockbridge-Munsee Community
N8476 Moh He Con Nuck Road
Bowler, WI 54416
(715) 793-4111
(715) 793-1307 Fax

**Forest County Potawatomi Community
P.O. Box 340
Crandon, WI 54520
(715) 478-7271
(715) 478-5280 Fax

**St. Croix Chippewa Indians of Wisconsin
P.O. Box 287
Hertel, WI 54845
(715) 349-2195
(715) 349-5768 Fax

**Menominee Indian Tribe of Wisconsin
P.O. Box 910
Keshena, WI 54135-0910
(715)799-5161
(715)799-1364 Fax

**Bad River Band of Lake Superior
Chippewa Indians
P.O. Box 55
Odanah, WI 54861
(715) 682-7134
(715) 682-7883 Fax

**Lac Courte Oreilles Band of Lake Superior
Chippewa Indians
Route 2, Box 2700
Hayward, WI 54843
(715) 634-8934
(715) 634-4797 Fax

**Chair
Oneida Early Childhood Education
Oneida Tribe of Indians of Wisconsin
N. 7210 Seminary Road
Oneida, WI 54155
(414) 869-4369
(414) 869-2894 Fax

**Sokaogon Chippewa Community
Route 1, Box 625
Crandon, WI 54520
(715) 478-7500
(715) 478-5275 Fax

**Ho-Chunk Nation
P.O. Box 636
Black River Falls, WI 54615
(715) 284-7548
(715) 284-9592 Fax

WYOMING

Administrator
Division of Health Care Financing
Department of Health
6101 Yellowstone Road, Room 259B
Cheyenne, WY 82003
(307) 777-7531
(307) 777-6964 Fax

EPSDT Coordinator
(307) 777-5601
(307 777- 6964 Fax

MCH Manager
Division of Public Health
Hathaway Building, Room 462
Cheyenne, WY 82002
(307) 777-7942
(307) 777-5402 Fax

CSHCN Manager
Division of Public Health
Hathaway Building, Room 467
Cheyenne, WY 82002
(307) 777-7942
(307) 777-5402 Fax

Child Care Consultant
Wyoming Department of Family Services
Hathaway Bldg., Room 373
2300 Capitol Avenue
Cheyenne, WY 82002-0490
(307) 777-3693
(307) 777-6848 Fax

**JTPA/Jobs Director
Shoshone and Arapahoe Tribes
P.O. Box 920
Fort Washakie, WY 82514
(307) 332-6320
(307) 332-9207 Fax

U. S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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Robin Brocato, Program Specialist
Health and Disabilities Branch
Head Start Bureau
P.O. Box 1182

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